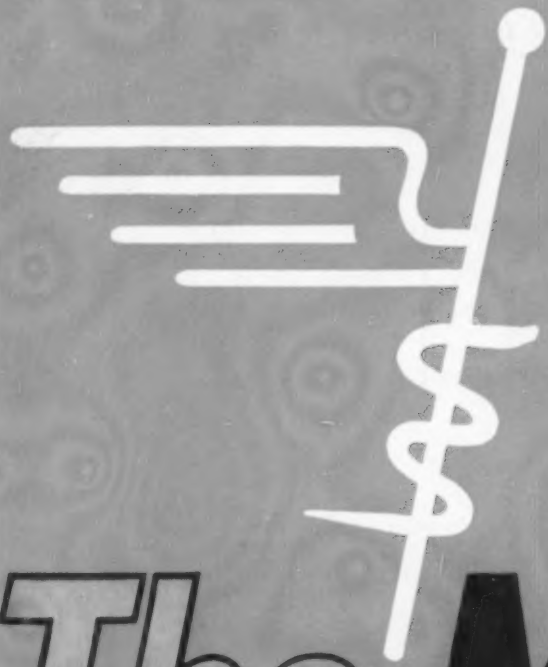
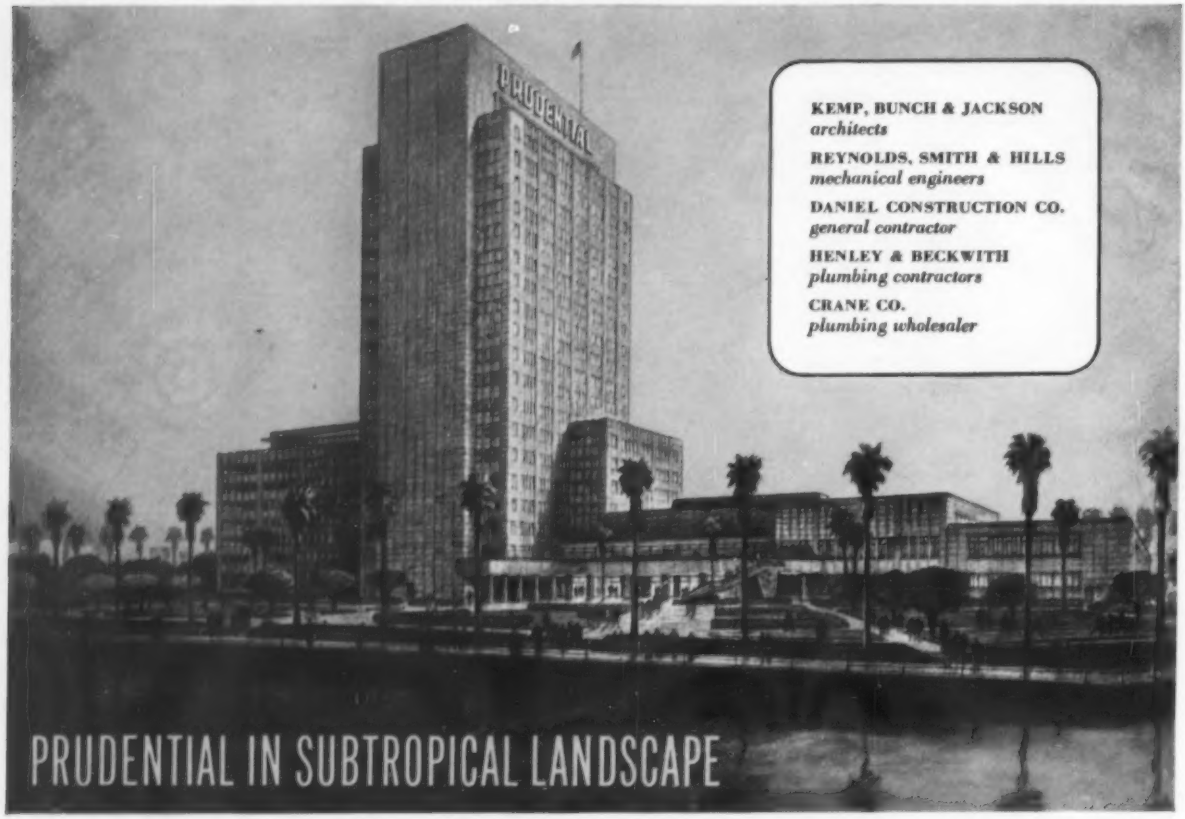


The Modern Hospital

MARCH 1955

Design Postmortem: Rockford Memorial Hospital • Lighting Recommendations • Synchronized Purchasing • Two Lines of Authority • Medical Audits • Iowa Hospitals Sue Doctors • Nursing Education Heads for Catastrophe • Hospital of the Year

THE VAST MAJORITY OF THE NATION'S FINE BUILDINGS ARE SLOAN EQUIPPED



SOUTHEAST'S TALLEST OFFICE BUILDING

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA will soon occupy its new 22-story South-Central Home Office at Jacksonville, Florida. This stately, 300-foot structure of steel, cloaked with Alabama limestone, North Carolina pink granite and Georgia white marble, is situated on 13 acres of luxuriant gardens bordering beautiful St. John's River, and rises higher than any other on the magical South Atlantic coast. The gleaming building can be seen from points 30 miles distant and an unparalleled panorama can be viewed from its roof deck. Service facilities within the building are ultra-modern: automatic high speed elevators, high capacity escalators, complete air conditioning, acoustical ceilings, recessed fluorescent lighting. On the main floor is an auditorium and lounge, separated by folding partitions. Combined, the two can accommodate 1000 persons. Public facilities include banking, shopping, eating, and parking for about 1000 cars. As are thousands of other fine buildings, including the new Prudential Building in Chicago, this one is completely equipped with SLOAN *Flush* VALVES—additional evidence that explains why...

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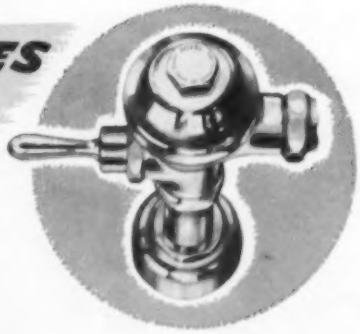
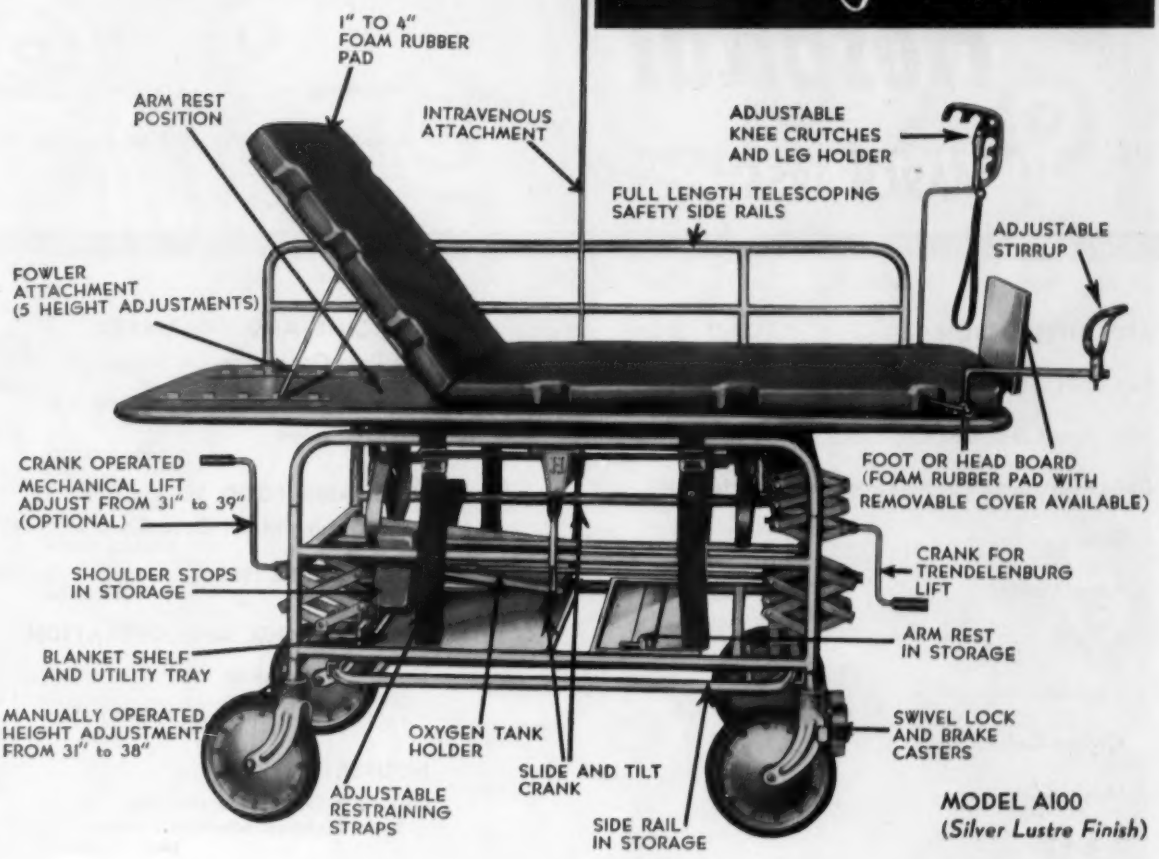


THE ORIGINAL
Slide and Tilt
Over-the-Bed Stretcher

HAUSTED
"Easy Lift"



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The exclusive Two-Way Slide and Tilt feature makes it possible to transfer patients to either side. This is particularly helpful in crowded rooms and wards where it is difficult to move the beds away from the walls.

Just fifteen seconds is required for even the smallest nurse or attendant to transfer a heavy patient from a Hausted "Easy Lift" to the bed.

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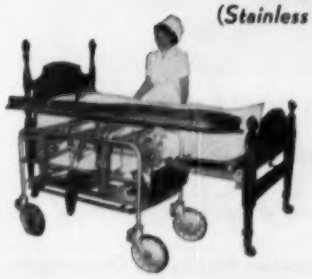

By a simple turn of the transfer crank the litter slides to either side and tilts onto the mattress, locking the stretcher and bed together. This makes an easy and safe transfer of the patient.
The smallest nurse can transfer the heaviest patient in 15 seconds.

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MEDINA, OHIO

The Modern Hospital

MARCH 1955

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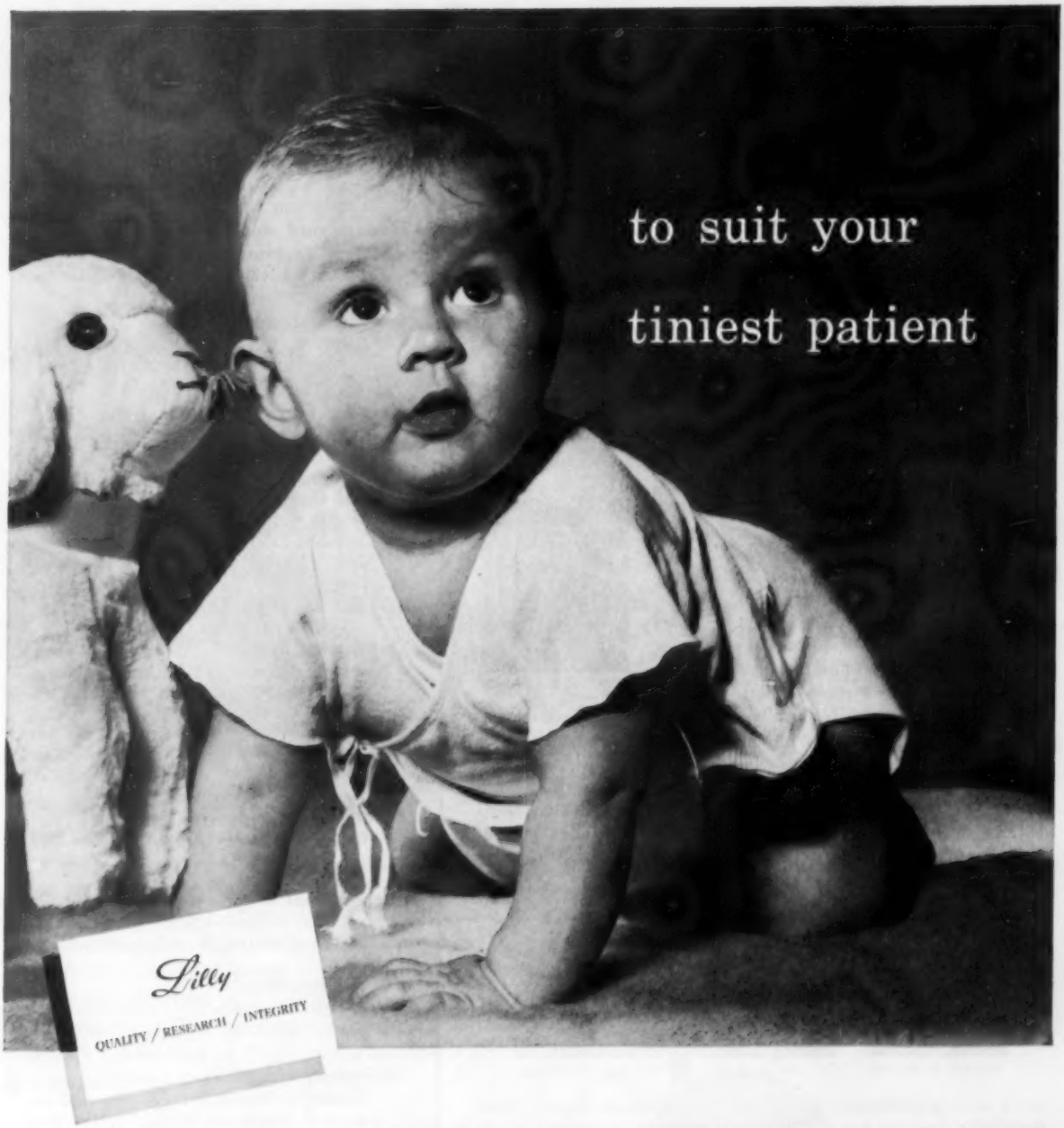

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AMONG THE AUTHORS


Harvey L. Smith

Harvey L. Smith is associate professor of sociology at the University of North Carolina and research associate in the Division of Health Affairs and the Institute for Research in Social Science at the university. Dr. Smith is engaged in a research and teaching program of liaison between social science and the health professions, including medicine and psychiatry; among other assignments, he is consultant in the social sciences to the University of North Carolina Memorial Hospital. A former member of the faculty of the University of Chicago, he received his Ph.D. in sociology there. During the war, Dr. Smith spent several years as medical registrar of an army general hospital overseas. Among his recent research programs, several studies of the social organization of hospitals have been included. The results of these studies are summarized in his article on page 59 of this issue.


Alfred E. Schlef

Alfred E. Schlef, author of the article on purchasing on page 89, is purchasing agent for the Bethesda Hospital at Cincinnati, where he has developed the system which he calls "synchronized purchasing," as described in the article. A graduate of Xavier University at Cincinnati, Mr. Schlef has his master's degree in economics. Before entering the hospital field he was with the Allis Chalmers Manufacturing Company. He is a member of the National Association of Cost Accountants.

The success story of the Sutter Hospitals auxiliary (*p.* 98) is the joint effort of three people who worked long and hard to establish and build it up. **Barbara B. Mackey,** the first president, has turned her energies in many directions in the past, including three years of service in the WAVES. Since her marriage in 1946, she has been


Barbara B. Mackey


John A. Rudd


Charmian W. Shrader

active in such community projects as the Sacramento County Heart Association and the Junior League. She is now a member of the community advisory committee for the Sutter Hospitals. Mrs. Mackey's co-worker and successor as president of the auxiliary, **Charmian W. Shrader,** found her experience as a teacher of shorthand and typing very useful in her first volunteer position with the auxiliary: that of recording secretary and administrative chairman. She has also worked with the United Crusade, the March of Dimes, and the Children's Receiving Home of Sacramento. As their guide and counselor in the organization of the auxiliary, Mrs. Mackey and Mrs. Shrader had **John A. Rudd,** then representing a national fund raising counsel. Mr. Rudd is now regional director of the Texas Heart Association. His new position represents a return to an old love since he organized the Florida Heart Association in 1950 and remained with it until October 1953. In 1941, Mr. Rudd had organized the Everglades Community for Migratory Farm Labor at Pahokee, Fla., and directed it until 1943, when he became a field director with the American Red Cross.

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Roving Reporter

La Verne Timeche, who is half Hopi, half Navajo, ministers to a patient.

Why She Chose Nursing

When a hospital loses one of its better new graduates to the public health field, the administrator and the director of nursing service may sigh in unison. What a floor staff nurse she would have made!

Yet Guy M. Hanner, administrator of Good Samaritan Hospital, Phoenix, Ariz., and the superintendent of nurses there were unselfishly glad to let La Verne Timeche out of their grasp. For La Verne, half Hopi and half Navajo, chose to do further study and then will return to her own reservation to assist the Indians of the tribe in turning from their old ways toward health, sanitation and broader living.

Before she completed her nursing course at Good Samaritan, La Verne was able to take part in an interesting public health study. The state health commissioner, Dr. Clarence G. Salsbury, thought it worth while to have investigated the alleged immunity of the Navajos to cancer, so he started a research project. La Verne was on a team of scientists that went to Ganado, Ariz., and while assisting the doctor in charge she had a chance to teach the native women some sanitary habits, especially in regard to their use of eating utensils.

La Verne came back to Phoenix, wrote up the project in her good English style, and then threw in for good measure an account of why she took up the study of nursing and what she hopes to do with what she learned. It's good recruiting material—for other Indian girls and for all girls. This is what she wrote:

"In this day and age there comes a time in each person's life when he must choose a type of work to do, whereby he can earn a living.

"In my case the choice was nursing. As I am finishing the three years of required study and work I feel more than ever I made the right choice.

"I was born on the Navajo Reservation without the aid of medical help. The first time I saw a nurse I was very much impressed with her clean white uniform. As I grew older I learned that a nurse does much more than model a clean white uniform.

"My decision to become a nurse was based on the realization that my people need nurses to help them in their times of sickness and also to teach them to help themselves. More and more the Indian people are turning from their old ways and are trying to better themselves. The way is not easy for it is always hard to turn from traditions. I think that much of the progress that the Indian people will make depends a lot on the younger members of the tribe. We should consider it our duty

The man behind the thumb

He visits you regularly and he's quickly within reach by telephone. He supplies you with surgical dressings, instruments, rubber goods, equipment—keeps your inventories level and fresh. He's "on the button," too, when emergencies strike. Responsibility, dependability, consideration are his watchwords. He's your Surgical Supply Dealer, the sole distributor of surgical products manufactured by The Seamless Rubber Company. This tribute to him is presented out of respect for the faithful, efficient services he gives you.

to achieve an education and return to help our own people.

"While working with the Navajo Cancer Research Project, I realized more fully the needs of my people and it is my present and sincere desire to further my education in public health. I feel that I can do more good in the public health field.

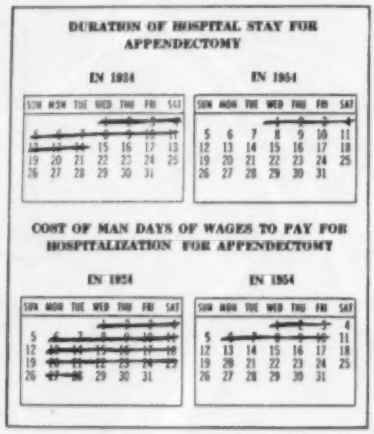
"The appreciation I feel for the help, guidance and education I received while attending the Good Samaritan School of Nursing cannot be expressed in words alone. As I leave the school I promise myself that I will use the knowledge I have gained here to the very best of my ability."

Calendar Explains Costs

What C. G. Crary read in the *Wall Street Journal* didn't convince him. He didn't write to the editor of that newspaper to refute the facts of the much publicized Cooper article; actually he agreed with the facts. With the implications of these facts and with the negative point of view expressed, however, Mr. Crary was in thorough disagreement. (You remember the article, "Sick Hospitals—Soaring Costs Keep Them Deficit Ridden," and the contention, "It is the rising cost of hospital labor that has us licked.")

Mr. Crary believes in the "success story" of hospitals, and armed with figures he went to the editor of the hometown paper, the *San Diego Union*, as Mr. Crary is administrator of Scripps Memorial Hospital in that city.

Maybe everybody in San Diego and environs did not read the long news story that the local paper printed, but



Calendar tells the story of costs.

the chances are that even the hurried reader's eye was caught by the calendar pages that illustrated this interview.

The calendar pages are reproduced here; the caption on them declared that a study of actual cases at Scripps Memorial Hospital was used to make the comparisons. The cost in man days of wages to pay for an appendectomy in 1924 and to pay for the same operation in 1954 was worked out with a slide rule from advertising done by the American Petroleum Institute. Mr. Crary now has exact figures from the Bureau of Labor Statistics. The average hourly wage earned by production workers in all manufacturing industries for the first six months of 1954 was $1.81. In 1925 the average hourly wage was $0.547.

In California the per capita income in 1925 was just under $600 a year, while in 1953 it was in excess of $1700 a year.

"Hospital deficits resulting from charity work should be labeled as such," Mr. Crary holds, "with no implication that they are the result of inefficient operation. Nor should abuse of welfare plans by members be placed on hospital operations."

The news story in the San Diego newspaper also compared costs of such

Beautiful Rockford Memorial Hospital

CHOOSES NCG® OXYGEN PIPING EQUIPMENT

The new Rockford Memorial Hospital at Rockford, Illinois, has aroused widespread interest and admiration—not only for its handsome exterior but for the new concepts embodied in its interior design.

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illnesses as gallstones and hernia in 1925 and 1954 and the comparative costs of a maternity case. His figures showed a decrease of 31 per cent in man days of labor to pay for an appendectomy; a 15 per cent reduction for gallstones; 28 per cent for hernia, and 24 per cent for childbirth.

Auction Raises $12,500

In Presque Isle, Maine, the Rotary Club has 110 members. Yet one week last autumn this club raised $12,500 toward a fund for putting a new wing on Presque Isle General Hospital.

The money raising demonstration didn't cause so much of a stir in this community of 12,000 population, because the Rotary Club was merely repeating a stunt it has promoted for the last seven years to the total tune of $100,000 for the hospital. It is great fun for the citizens and it takes real business organization on the part of the Rotarians. This year's take was notable in a way because for two years the Aroostock potato farmers have not had their customary good yields, the hospital administrator, Matthew J. Ustas, reports.

For four nights preceding the Thanksgiving holiday each year, the Rotarians conduct an auction by radio. For the previous five months they have been busy soliciting items—a buckwheat cake supper for a party of six at the Urquhart home, a four-day hunting trip at McKeen Crossing for a party of two, including two guides, from Donald Giberson, a hand-made white cedar chest from Willard Ricker ("Mr. Ricker was in the hospital last year and was very well pleased with the way he was treated"); six 50 lb. bags of Russett Burbank hand picked table potatoes from Arthur Lovely, delivered; a foam rubber tractor cushion from Hants White of Mars Hill; one dacron filled twin sleeping bag, full length underpocket, removable overhead canopy from Sears, Roebuck, and so on through literally thousands of fascinating items.

Each item is listed by number, description, retail value, and name of the giver in a printed booklet, which is distributed throughout Presque Isle and 14 surrounding communities. On the four big November nights one page of merchandise is auctioned each half hour; at the end of that time the items are sold to the highest bidder. Bids come in by telephone over four direct lines and eight or 10 telephones are manned by a pair of Rotarians, one

"Thumbs up" means "this is a low bid."

of whom repeats the number of the item bid upon, the amount of the bid, and the name and address of the bidder, and the other records the information on a slip of paper. Two men stationed at a blackboard read these slips and put down the highest bid for each item at all times for the telephone crew to see. They can then tell the caller the highest bid, thus cutting down time and extra calls.

After the bid is posted on the board, it goes to one of two (alternating) auctioneers in the broadcasting room, who describes the items to the bidders, reads the bids, and stimulates further bidding. A signal system operates at this point. If the total sum of the bidding equals or exceeds the retail value of the item (printed in the catalog), this auctioneer gets a Green Light. If it goes 10 per cent above the retail value, he gets a Red Light. Near the end of the half hour a three-minute bell rings a warning to all bidders to get in one last bid. All bids on the same item number are clipped together and go to auditors, who record the highest. The final list of successful bidders is announced during the next half hour.

The auctions take place on the local radio station from 7:30 to 11 p.m. each of the four nights. The cost of publishing the booklets and the staff that has been manning the warehouse for donated goods in a vacant store on the main street for a week preceding (and will man it for two weeks after) the auction is met by advertisements in the booklet of auction entries.

For further information, write the hospital administrator. He is fairly new in those parts and when he saw his first Rotary radio auction in action his one adjective was "terrific." The Rotary Club at Portland is said to have its spies out so these Rotarian prophets may not be long without honor in their own country.

READER OPINION

10 Cent Error

Sirs:

It has been called to my attention that in The MODERN HOSPITAL Round Table for October 1954, I stated that the raw food costs at our hospital are 19 to 22 cents, and the total cost is 42 cents. There was a misunderstanding about our raw food cost being 19 to 22 cents; instead, it is 29 to 32 cents, a 10 cent error. Further, salaries are about 9 cents and miscellaneous, about 1 cent.

W. I. Fender Jr.
Administrator
Mary Black Memorial Hospital
Spartanburg, S.C.

Room for Records? Yes

Sirs:

In reading "Nurses' Station Is the Heart of the Plan" by Edwin B. Crittenden in the October 1954 issue of The MODERN HOSPITAL and studying the floor plan of the hospital, I cannot help but notice that the medical records department has been completely ignored in the floor plan. I am wondering what they plan to do with their medical records, for regardless of the size of the hospital—if they have patients, they will have medical records.

As a medical records librarian it disturbs me very much for a hospital of such qualifications as to be selected as the "Modern Hospital of the Month" to exclude a medical records department in their planning.

Naomi L. Ladson, R.R.L.
Medical Records Librarian
The Methodist Hospital
of Kentucky
Pikeville, Ky.

Sirs:

Thank you for your letter of January 4th in regard to the Valley Presbyterian Hospital and the provision that was made for medical records.

In the planning, as well as the actual use of the hospital, a space in the corridor outside the administrator's office is used for record files. This provides a large bank of file cabinet space, which is at once accessible to the nurses' station and to the business office. With the limited staff available for the operation of the hospital, the files are easily accessible and still out of the range of casual visitors.

I hope this information will satisfy your reader and we are pleased to know that the hospital has caused some interest.

Edwin B. Crittenden
Edwin B. Crittenden
and Associates, Architects
Anchorage, Alaska

Housekeeping Needs

Sirs:

I read with interest your article in the October issue about housekeeping employes being taught how to do their work properly. The title of the article is "Who Says You Can't Teach Them." It is very well done and I would appreciate having a copy of the series of lectures. I would pay you for them. It is a department that needs attention in many hospitals.

Sister Flora Mary
St. Vincent's Hospital
Portland, Ore.

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Supplied in 2½″ x 4″ and 3″ x 8″ Strips, in hospital cases; and in 2″ x 3″ sterilized envelopes for doctors' offices.

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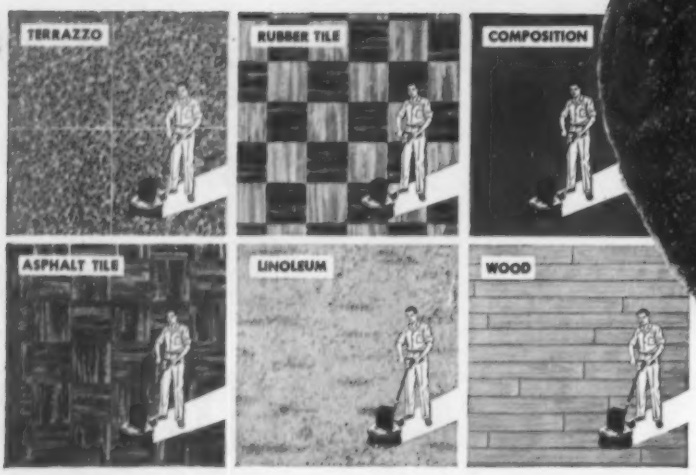

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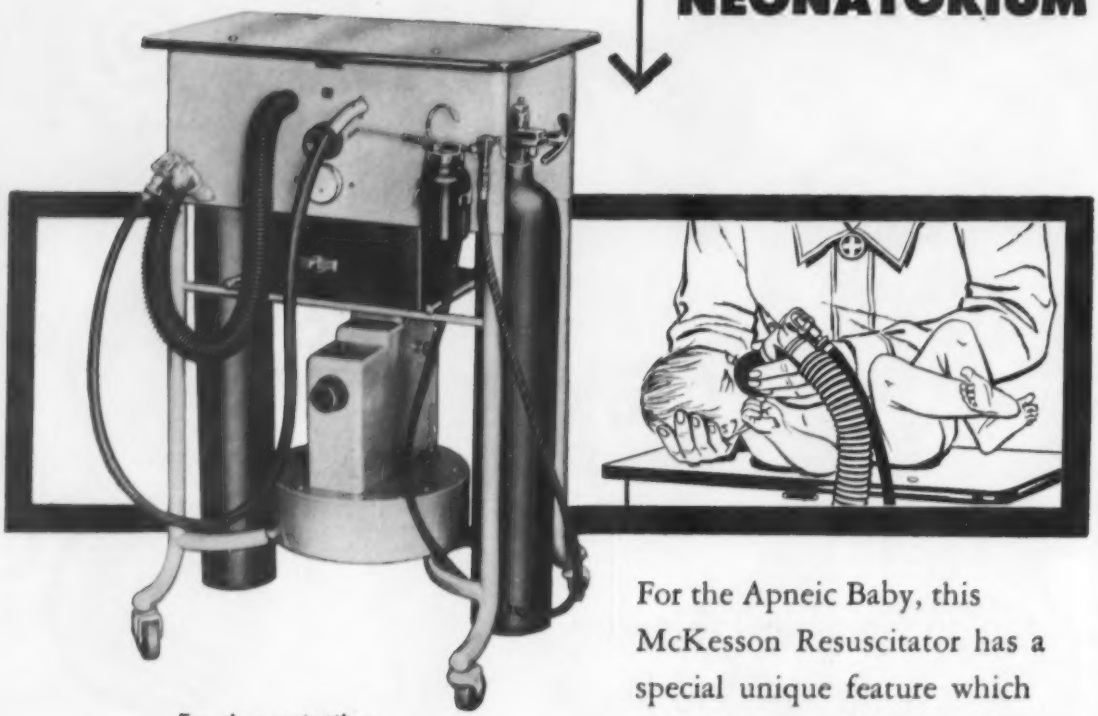

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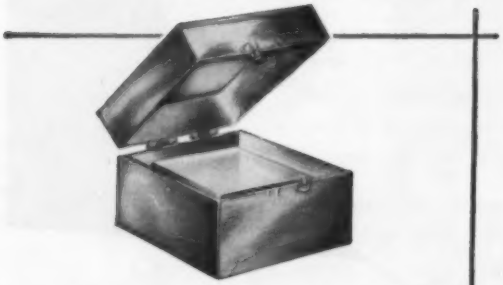
Hand selected for uniformity and perfection

GLASCO MICROSCOPIC SLIDES



GLASCO COVER GLASSES

Uniformly cut and flat on both sides, Glasco Cover Glasses are carefully made to assure high quality. They are packed in a unique plastic package that keeps the glass free from dust and moisture. You'll find many uses in the laboratory for these handy little boxes after you have used the cover glasses.

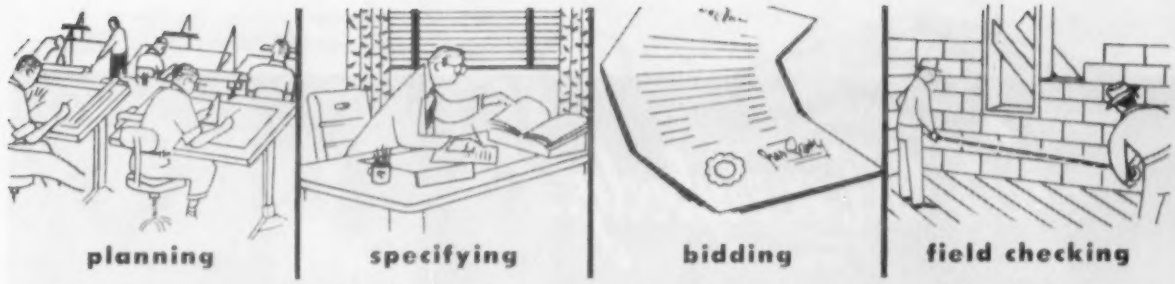
No matter what your slide preference—thick, thin, white or off-white—there is a Glasco slide available.

All Glasco slides are made from the highest quality American-made glass. They are hand selected for uniformity and perfection.

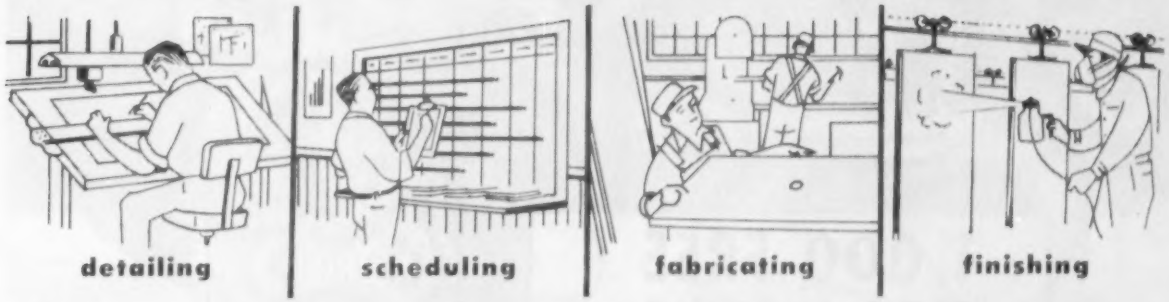
Get the best. Specify Glasco Microscopic Slides the next time you order. They are available from your hospital supply house. If you would like a *free catalog* showing the complete Glasco line and price listing, just write to the address below.

GLASCO PRODUCTS CO.

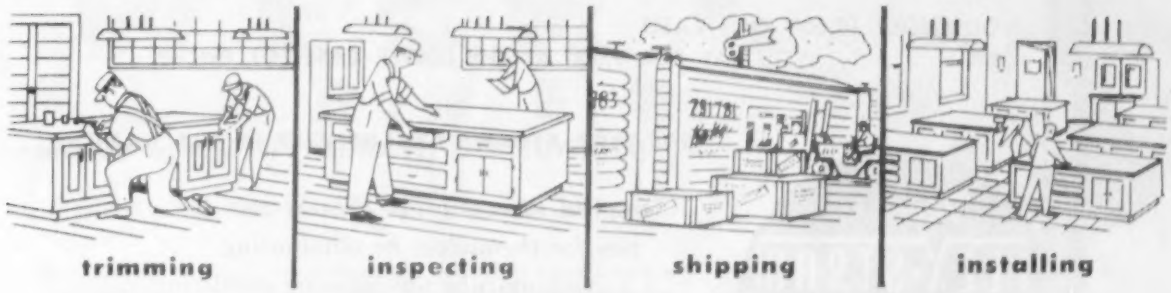
111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS



12 steps in every laboratory job



12 reasons why it's smart to allow



adequate lead-time

when ordering laboratory equipment!

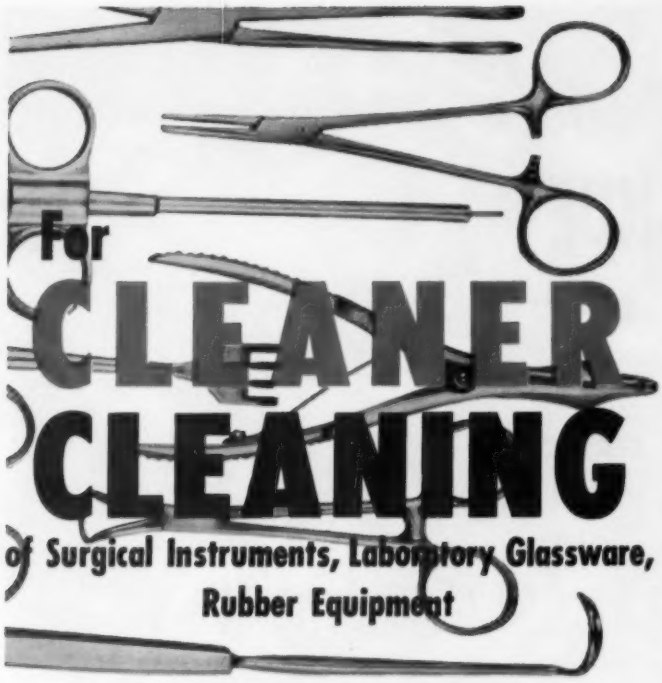
If your new laboratory is to be a good one, all these steps (and many others not shown here) must be done, and done right. This requires a tremendous background of experience, skilled planners and workers, highly specialized manufacturing facilities—and time.

When planning a new laboratory, use this simple formula to insure lasting satisfaction . . . *see that your contract is placed with a specialized manufacturer of laboratory equipment, and allow adequate time for completion of his work.*

For your FREE copy of Better Laboratory Planning, 28 pages of photos and planning data, write to Dept. C-

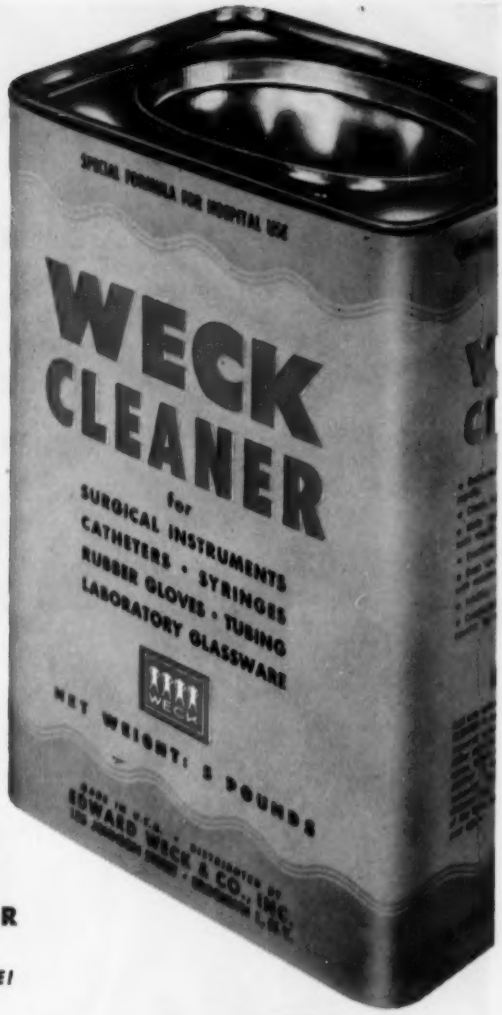
LABORATORY EQUIPMENT SECTION • SCIENTIFIC APPARATUS MAKERS ASSOCIATION

20 North Wacker Drive • Chicago 6, Illinois



For CLEANER CLEANING

of Surgical Instruments, Laboratory Glassware, Rubber Equipment



WECK CLEANER

—offered by an INSTRUMENT MANUFACTURER

Read these facts about this revolutionary new Cleaner and COMPARE!

After years of research, Weck introduces WECK CLEANER with the assurance that there is no finer instrument cleaner on the market. Here are the FACTS about this revolutionary new product:

- **Removes clotted blood and other contamination rapidly.**
- **Cleans effectively even in the hardest water.**
- **Wets, penetrates, dislodges and emulsifies all soils rapidly.**
- **Dissolves rapidly in warm water.**
- **Does not produce foam which would interfere with mechanical washing.**
- **Inhibits corrosion of surgical instruments.**
- **Completely safe to use. Does not contain free caustic. No more alkaline than a neutral soap.**

We suggest that you order a 5 pound can of WECK CLEANER. If you are not more than satisfied with the results we will gladly refund your money.

PRICES PER 5 LB. CAN WITH MEASURING SPOON:	1 can $5.30 3 cans 5.00 each 6 cans 4.80 each 12 cans 4.60 each

*Remember—***WECK** *is world-famed for Surgical Instrument Repairing*

If you ask me—
any product that will clean thermometers and formula bottles and nipples will clean anything. And, in my opinion, the best job is done by the new WECK CLEANER.

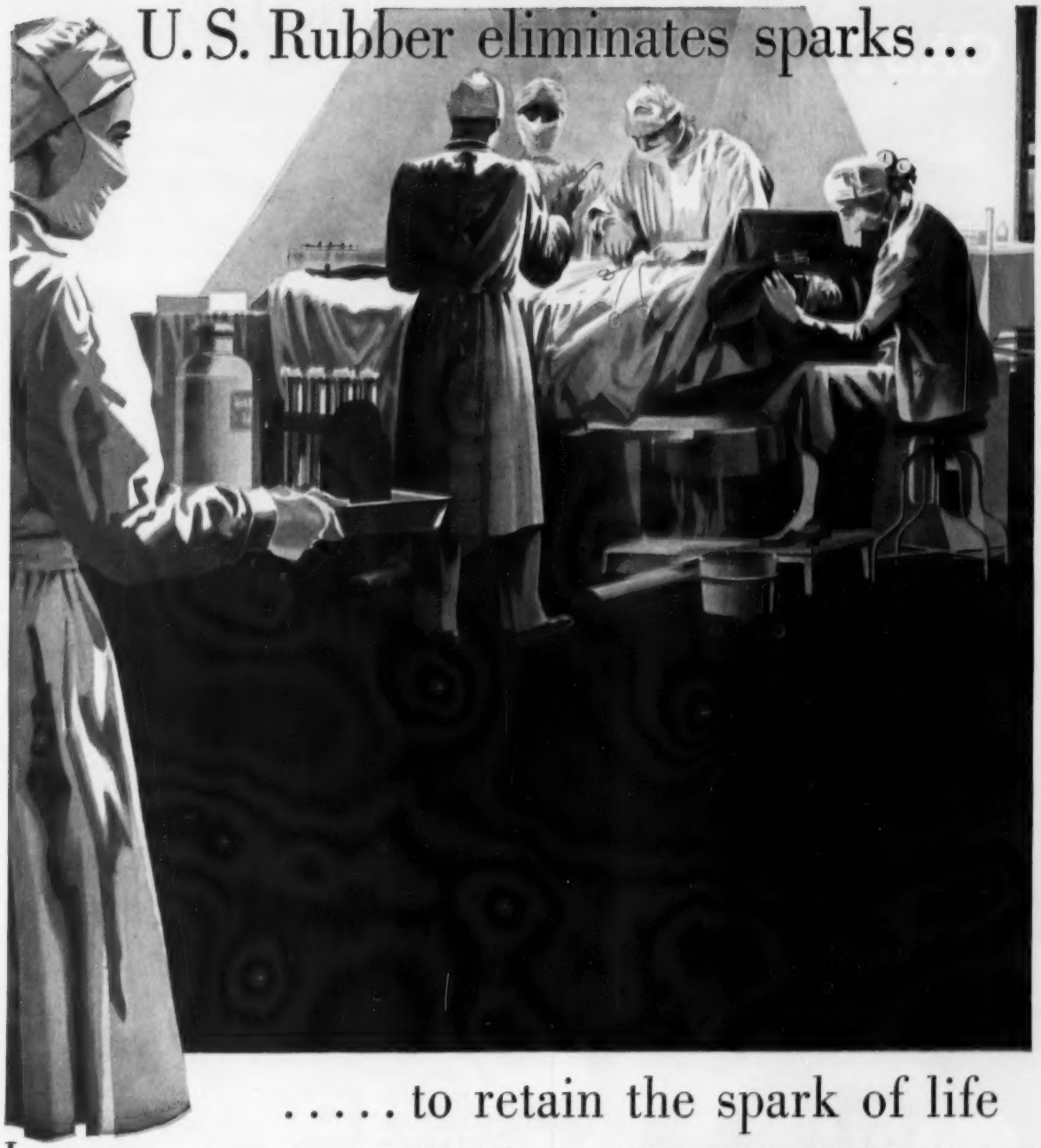
Founded 1890

EDWARD WECK & CO., INC.

135 JOHNSON STREET • BROOKLYN 1, N. Y.

Manufacturers of Surgical Instruments • Hospital Supplies
Instrument Repairing

U. S. Rubber eliminates sparks...



..... to retain the spark of life

In an operating room the very friction from walking, or the rubbing of clothes, could easily generate enough static to start a spark from the ordinary floor. The spark, igniting highly inflammable anesthetic gases, would cause a disastrous explosion. But no sparks occur with U. S. DURITE HOSPITAL FLOORING*, made of *conductive* rubber, because it prevents the accumulation of dangerous electric static charge. This material is not only completely spark- and skid-proof, it is also long-wearing, easy to clean, and very good-looking.

Here is one of the 30,000 ways in which "U. S." serves every phase of life—whether it be in the home, in industry, in transportation or medicine. Whatever the "U. S." product you choose, you can be sure it is a *quality* product that gives you more *economy*. Our 27 District Sales Offices, each with its staff of engineers, are at your service. Or write to address below.

**Approved by Underwriters' Laboratories, Inc.*

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"U. S." Research perfects it..."U. S." Production builds it...U. S. Industry depends on it

UNITED STATES RUBBER COMPANY

MECHANICAL GOODS DIVISION · ROCKEFELLER CENTER, NEW YORK 20, N. Y.

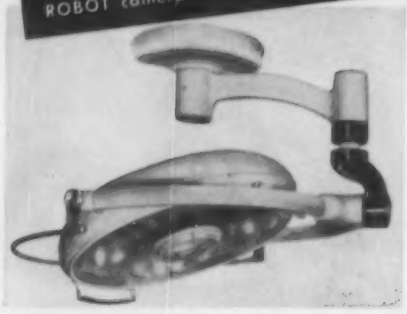
Hose • Belting • Expansion Joints • Rubber-to-metal Products • Oil Field Specialties • Plastic Pipe and Fittings • Grinding Wheels • Packings • Tapes Molded and Extruded Rubber and Plastic Products • Protective Linings and Coatings • Conductive Rubber • Adhesives • Roll Coverings • Mats and Matting

CASTLE LIGHTS *pace the industry*

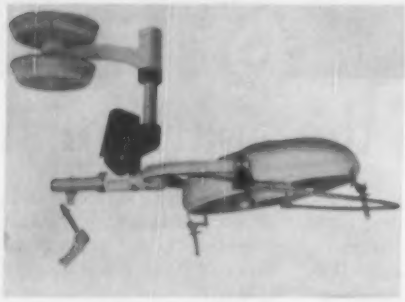
A radically new concept in directional control, mechanical compactness, improved vision, and patient safety is presented in Castle's

"60" SERIES MAJOR SURGICAL LIGHTS

IMPORTANT — Center Spotlight can be easily removed and replaced with ROBOT camera.



No. 61 – Dual offset arm without vertical adjustment.



No. 63 – With vertical adjustment and remote control (features which may be added to other model)

HEAR THIS —

LIGHT WHERE THE SURGEON NEEDS TO SEE — A fixture so easily moved that the surgeon's visual need is instantly met. Without breaking sterile technic, any member of the surgical team can direct the beam with only ounces of pressure on sterilized control handles.

MULTI-USE CENTER SPOTLIGHT — In addition to 4 major reflectors, an exclusive Center Pilot Spotlight provides extra penetrating power and an emergency lighting source. Projecting an 8-inch pattern deep into the incision, the pilot spot also acts as a pre-operative positioning guide to insure visual accuracy of light placement. An excellent auxiliary brain light or independent illuminator for ophthalmic surgery. Can be connected to automatic emergency circuit.

OBJECTIONABLE COUNTER-BALANCING BALL ELIMINATED — A newly devised INTERNAL CAM BALANCE obsoletes the conventional ball-type counterweight and provides "feather-touch" mechanical controls that are self-locking in any position.

ELIMINATES REPOSITIONING OF TABLE — A small central mounting with a dual offset arm provides continuing 360° rotations on 3 axes, without stops. Lamphead may be extended, lowered or tilted to any point within an 8'3" diameter circle, making it unnecessary to move operating table during any operation.

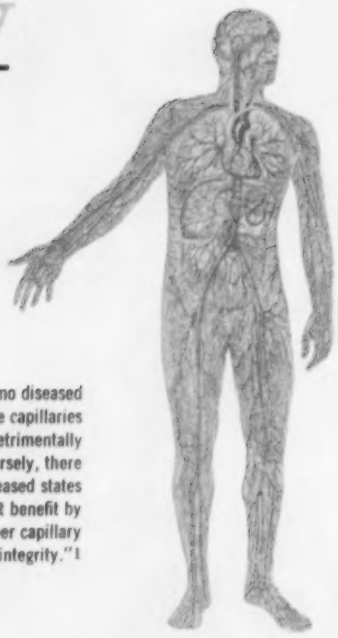
Castle LIGHTS AND STERILIZERS

WILMOT CASTLE COMPANY, 1255 University Ave., Rochester 7, New York

Send data on the "60" Series Lights.....

.....

new



Exerts a biochemical synergism

"... there is no diseased state in which the capillaries are not detrimentally modified. Conversely, there are no diseased states which will not benefit by assuring proper capillary strength and integrity."[1]

to restore normal permeability

In 1945, The National Drug Company made available the *first* oral hesperidin-ascorbic acid preparation. Now, *National* offers HESPER-C . . . a new and more potent synergistic combination of hesperidin—*the* active principle of citrin (Vitamin P mixture)[2, 3, 4, 5]—and ascorbic acid.

Hesperidin is essential for the absorption and retention of ascorbic acid.

In addition, hesperidin appears to catalyze the combining of ascorbic acid with a protein to form the intercellular cement which protects capillary integrity.

DOSAGE: Initially, 6 capsules or more per day for the first week. Then 4 capsules daily.

Note: Clinical experience shows that success in restoring capillary integrity is in direct ratio to adequate dosage.

SUPPLIED: HESPER-C (hesperidin, 100 mg., and ascorbic acid, 100 mg.) capsules, in bottles of 100 and 1000.

By or on prescription only.

The National Drug Company
Philadelphia 44, Pa.

Indications*:

Obstetric Management

Spontaneous Abortion—Early or Late
Postpartum Hemorrhage
Prophylaxis—Prenatal Care and Lactation

Cardiovascular and Cerebrovascular Diseases—Hypertension
Diabetes—Diabetic Retinopathy
Vascular Purpuras—Idiopathic Purpuras
Infections—Rheumatic Fever, Tuberculosis
Ocular and Retinal Hemorrhage: Pre-Retinal Edema
Hematuria—Hemorrhagic Nephritis
Bronchial Asthma—Allergic Purpuras
Prevention of Vascular Damage in Roentgen and Anticoagulant Therapy
Stress
Toxicity—Due to Chemical Agents
Fractures
Surgery—Disruption of Wounds

References:

1. Martin, G. J. (Editor): *Hesperidin and ascorbic acid. Naturally occurring synergists.* Basel, Switzerland. Messrs. S. Karger, 1954.
2. Bentsath, A.; Rusznyak, St. and Szent-Gyorgyi, A.: *Nature* 139: 326, 1937.
3. Bacharach, A. L.; Coates, M. E., and Middleton, T. R.: *Biochem. J.* 36: 407, 1942.
4. Bourne, G. H.: *Nature* 152: 659, 1943.
5. Zacho, C. E.: *Acta path. et microbiol. scandinav.* 16: 144, 1939.

*Send for new HESPER-C brochure with Paul Peck drawings.

to prevent capillary fragility

Hesper-C Capsules

NATIONAL

A new formulation of hesperidin and ascorbic acid

(based on the original research in bioflavonoid—ascorbic acid synergism by the National Drug Research Laboratories)

Powers Thermostatically Regulated Showers

Continuous Flow Bath—Note Powers Control Cabinet

Large Water Heaters—Powers Controlled

HINSDALE, ILL. SANITARIUM AND SHOWS DIVERSITY OF POWERS

★ FOR HEATING ★ AIR CONDITIONING ★ WATER HEATERS ★ HYDRO-THERAPY ★ SHOWER BATHS

Few 200 bed institutions are as well equipped to save and prolong lives as Hinsdale's Sanitarium and Hospital

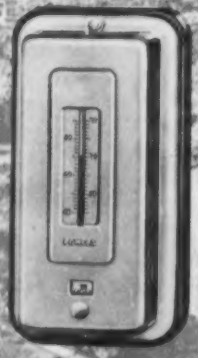
It's six operating rooms, X-Ray department (including a 250,000 volt deep-therapy machine for cancer treatment), delivery rooms, beautiful nursery and obstetrical department are all equipped with the best modern equipment.

Outstanding Polio Treatment Center. Facilities here can accommodate up to 30 polio patients and keep them in complete isolation.

Three iron lungs, rocking beds, steam rooms and many types of hydro-therapeutic baths under the care of skilled attendants provide patients with the best service obtainable.

Comfort and Safety of Patients here is assured by the dependability of Powers thermostatic controls used throughout the building.

When you want help in selecting the right type of control for hospitals or any other type of building, call in an experienced Powers engineer. There's no obligation. (1-55)



THE POWERS REGULATOR COMPANY

SKOKIE, ILL. • Offices in Over 50 Cities in U. S. A., Canada and Mexico

OVER 60 YEARS OF AUTOMATIC TEMPERATURE CONTROL

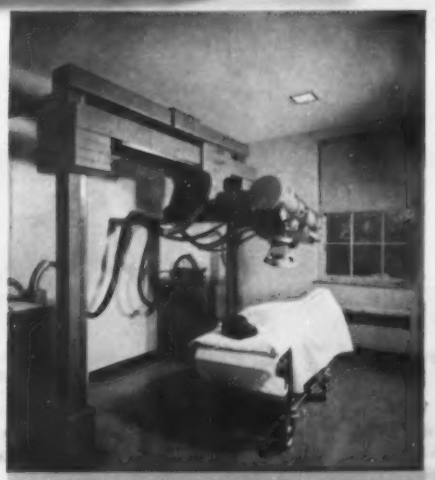
Scotch Douche and Hydrotherapeutic Showers are Both Powers Controlled

One of Three Iron Lungs in Children's Room

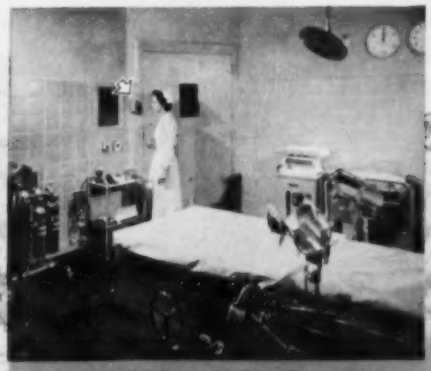
Steam Rooms Regulated by Powers Thermostats

HOSPITAL TEMPERATURE CONTROL

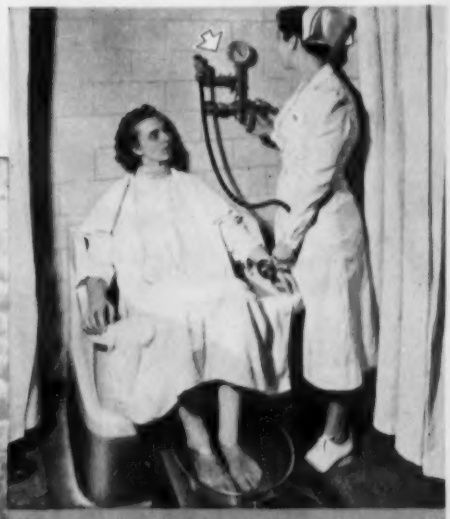
Architects and Engineers: **Fugard, Burt Wilkinson and Orth • Edward G. Halstead**
General Contractor: **E. H. Marhoefer Jr. Co.**
Contractors: **Thomas J. Douglass & Co.** (Heating) • **Charles E. Gazin** (Plumbing)
Plumbing Fixtures: **American-Standard**
All of Chicago, Ill.



Deep Therapy X-Ray Room



Air-Conditioned Delivery Room

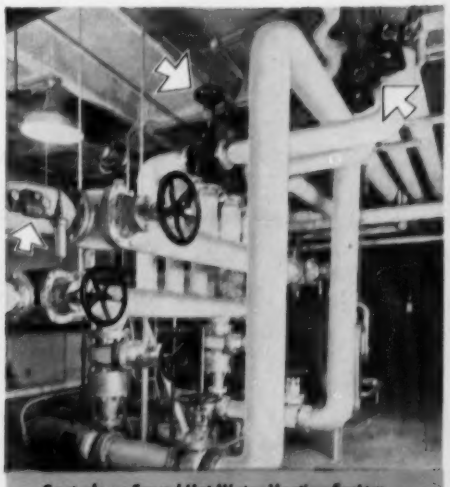


Powers Control on Sitz Bath with Raised Base

Treatment Bath for Children. Note Powers Mixer

Section of Nursery

Powers Controlled Whirlpool Bath for Polio Patients



Controls on Forced Hot Water Heating System

you asked us to create

no other paper cup has these 2 exclusive features

1. **The "bumper-roll edge".** This distinctive feature gives the consumer a completely new feel for paper cup drinking, makes it more pleasant, makes it easier.

2. **Porcelainized completely.** With Sealright's famous years of know-how in plasticizing paper, plastic is completely impregnated into paper — top to bottom, inside and out. Plasti-cup is the first paper cup that makes you think you're drinking from a china cup.

PLASTI-CUP IS A NEW PAPER PRODUCT OF

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SEALRIGHT CO., INC., FULTON, N. Y. MH553

I'd like to try the new Plasti-cup myself. Please send me two dozen.

Name ..... Title .....

Company .....

Address .....

City ..... Zone ..... State .....

My Distributor's Name .....

Here's how

HIGH HUMIDITY THERAPY

has progressed

first came	**LIVE STEAM**
then came	**SPINNING HUMIDIFIERS**
then	**NEBULIZED WATER VAPOR**
then	**HIGH HUMIDITY INSUFFLATORS**
then	**HUMIDITY TENTS**

AND NOW . . .

AN ENTIRE HOSPITAL ROOM WITH

Actual photograph of Humidity Room with Melco "Natural Fog" Generator in operation.

COOL, COMFORTABLE, MOIST "NATURAL FOG"

What is "Natural Fog"?

When nature combines two streams of air, one chilled and the other heated, the result is "Natural Fog." Now, man has been able to duplicate nature, and even to improve upon it, in that the heated stream of air can be supersaturated, and temperature prescribed.

You can now for the first time completely fill an entire hospital room with dense supersaturated fine fog without precipitation. You can now maintain in that room any temperature you prescribe between 68° and 85°. The Melco "Natural Fog" Generator makes this possible.

Here is a unit that can convert any hospital room into a Humidity or Croup Room . . . a room that completely eliminates the adverse conditions of excessive heat and precipitation prevalent in existing Humidity Rooms.

Microscopic droplets of water are needed to penetrate the tiny filaments of the patient's respiratory system. When precipitation occurs, these droplets have agglomerated into clusters of water too large to reach and moisten the microscopic bronchioles which feed air to the patient's lungs.

The Melco "Natural Fog" Generator removes the large droplets by cooling, warming and recirculating the air. There is thus no chance for agglomeration. Without agglomeration there can be no precipitation. Without precipitation, true supersaturated humidity is administered to the patient. The physician prescribes the temperature . . . the patient remains cool, comfortable and dry.

IMPORTANT

A letter stating the dimensions of your present humidity facilities, or the room to be converted, will immediately bring you complete information and prices. Even if you are not contemplating a Humidity Room at the present time, we are sure that you will want this information in your files. Write Medical Equipment Division, Melchior, Armstrong, Dessau Co., Ridgefield, N. J.

Melco

Medical Equipment Division

MELCHIOR, ARMSTRONG, DESSAU CO.

OF DELAWARE INC.

RIDGEFIELD, NEW JERSEY

PARTIAL LIST OF DISEASES AND CONDITIONS WHERE THE USE OF HIGH HUMIDITY THERAPY WITH CONTROL OF TEMPERATURE MAY BE INDICATED

EXCESSIVE OR THICKENED BRONCHOPULMONARY SECRETIONS SUCH AS:

- neonatal asphyxia due to partial intrabronchial obstructions
- neonatal atelectasis
- cystic fibrosis
- asthma
- bronchitis
- lung abscess
- laryngotracheobronchitis
- pertussis
- bronchiectasis
- bronchopneumonia
- emphysema

SECRETIONS ALSO ACCOMPANYING:

- diaphragmatic paralysis due to poliomyelitis or encephalitis and pulmonary abscess
- general anesthesia
- thoracic surgery
- tracheotomy
- inhalation of noxious gases or dusts

ASPIRATION OF MATERIALS SUCH AS:

- foreign bodies
- gastric contents
- amniotic fluids

Write for complete information on how the Melco "Natural Fog" Generator can convert any hospital room into a Humidity Room capable of supplying supersaturated humidity with temperature control and without precipitation.

Melco

Medical Equipment Division

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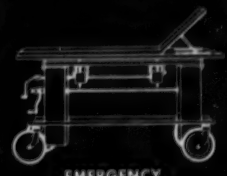
SHAMPAINE *Trans-All* DOES ALL THIS-

--and ONE ATTENDANT easily performs all over-bed transfer and transport functions with SINGLE END CONTROLS.

The TRANS-ALL is the perfect stretcher for Recovery Room use, and bypasses the need for intermediate transfer during the entire Recovery Room period. For all purposes, the TRANS-ALL is a versatile, comprehensive stretcher for every hospital.

RECOVERY STRETCHER
—Trendelenberg position

REVERSE TRENDELENBERG



EMERGENCY TREATMENT TABLE
—all height adjustments

OVER-BED PATIENT TRANSFER
—tilts to right or left

AND MANY OTHER USES!

Shampaine COMPANY

MANUFACTURERS OF A COMPLETE LINE OF PHYSICIANS' AND HOSPITAL EQUIPMENT

SHAMPAINE COMPANY, Dept. MH 5-3
1920 South Jefferson
St. Louis 4, Missouri

Please send literature on the new Shampaine TRANS-ALL Stretcher.

My dealer is.....

Name.....

Address.....

City.....Zone.....State.....

TO INCREASE THE COMFORT OF THE PATIENT

Choose

LUDMAN Auto-lok AUTOMATIC LOCKING WINDOWS

SEALS TIGHTER THAN A REFRIGERATOR ....

Your hospital board can profit by the experience of other boards that have earned the gratitude of patients and community alike by adding more comfort to every room, and yet achieving lower maintenance costs and greater operating ease through the use of Auto-Lok windows.

Countless successful hospital installations, continuing work with the architects of hundreds of America's most modern hospitals, and the specialized skills gained through designing and producing windows for outstanding public buildings .... all contribute to Ludman's leadership in hospital window installations.

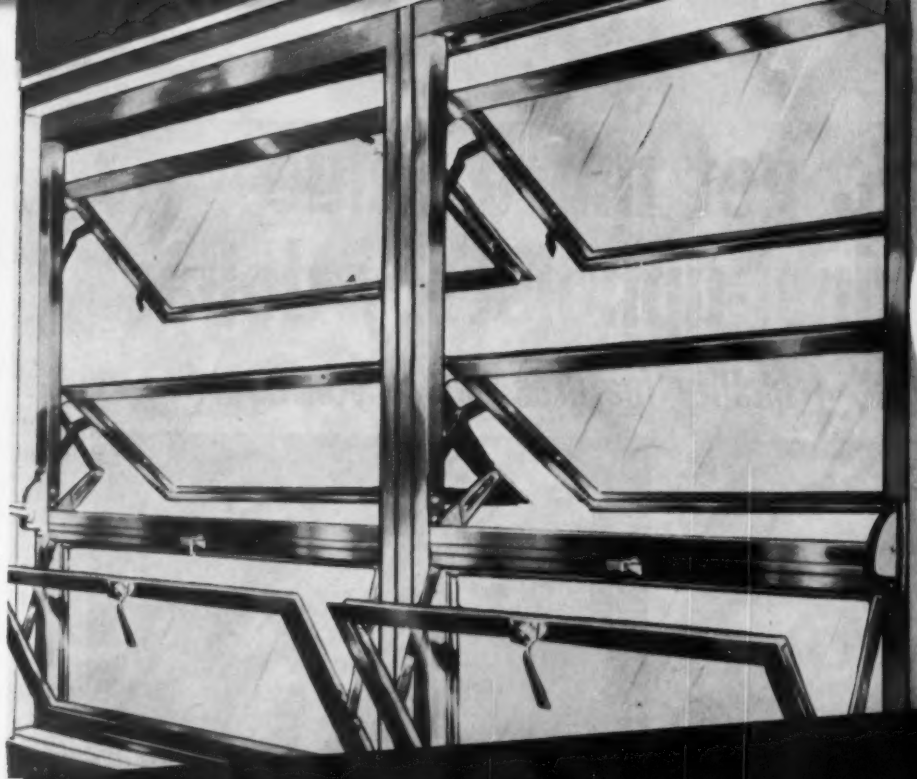
The coupon below will bring you, in full detail, the information you need to look ahead in your selection of hospital windows. To learn why Auto-Lok windows meet the ten most important requirements that experts* agree are really important in a window .... to learn how Auto-Lok windows insure healthful fresh air, even when it's raining .... to learn of such savings as reduced fuel costs .... to learn how you save with windows that are washed from inside .... send the coupon today.

*Geoffroy Baker and Bruno Funaro in "Windows in Modern Architecture".

SPECIALISTS IN BUILDING HOSPITAL WINDOWS ....

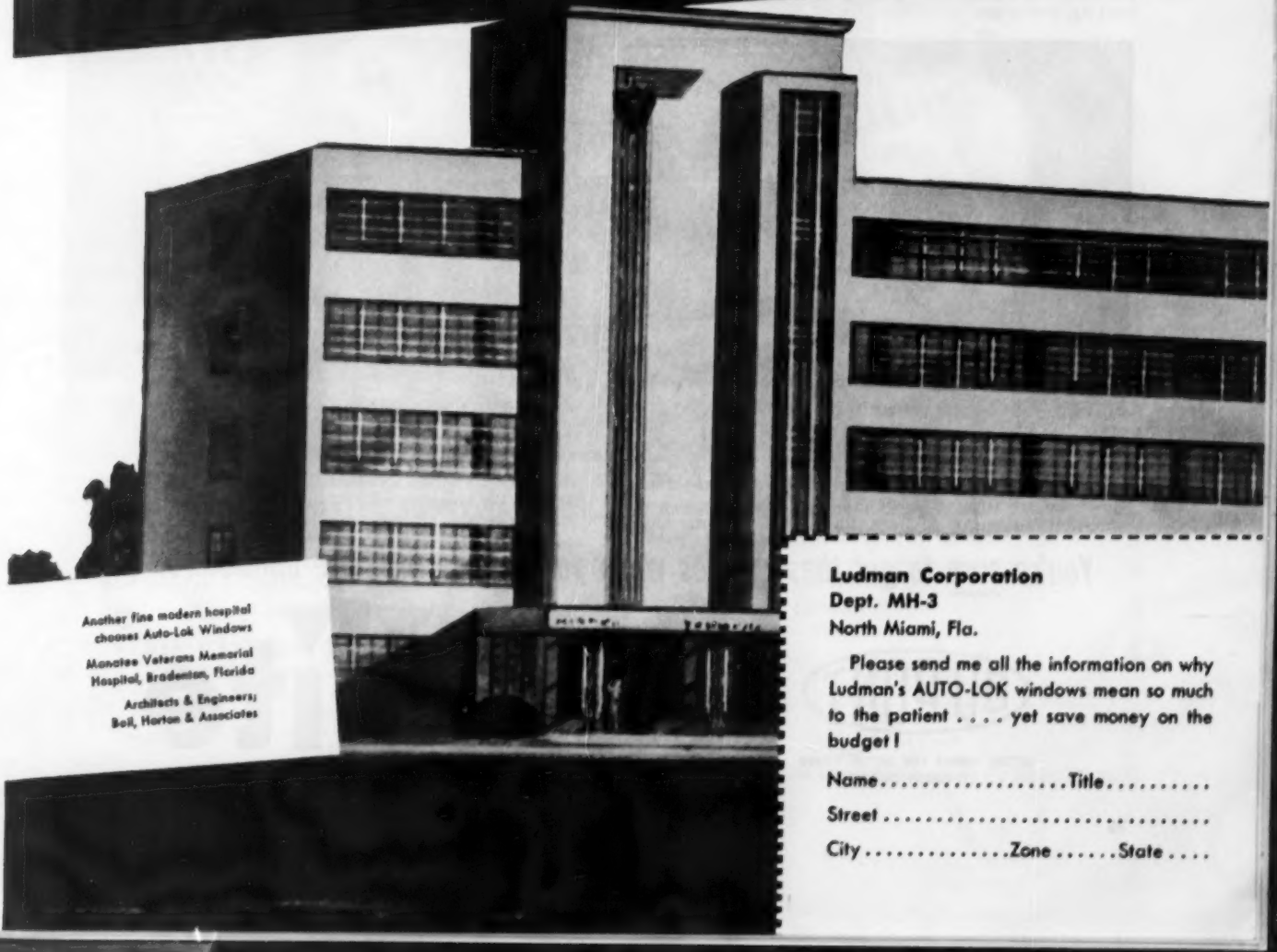
LUDMAN *Corporation* • NORTH MIAMI • FLORIDA

LEADS THE WORLD IN WINDOW ENGINEERING



EASIER FOR
YOUR NURSES
TO OPERATE

WITH LOWER MAINTENANCE COSTS!



Another fine modern hospital
chooses Auto-Lok Windows

Manatee Veterans Memorial
Hospital, Bradenton, Florida

Architects & Engineers;
Bell, Horton & Associates

Ludman Corporation
Dept. MH-3
North Miami, Fla.

Please send me all the information on why Ludman's AUTO-LOK windows mean so much to the patient . . . . yet save money on the budget!

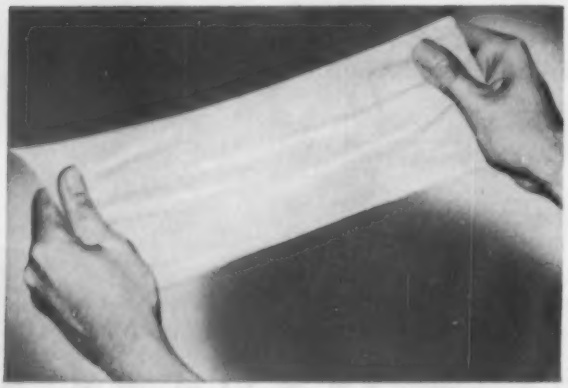
Name . . . . . Title . . . . . .

Street . . . . . .

City . . . . . Zone . . . . . State . . . .

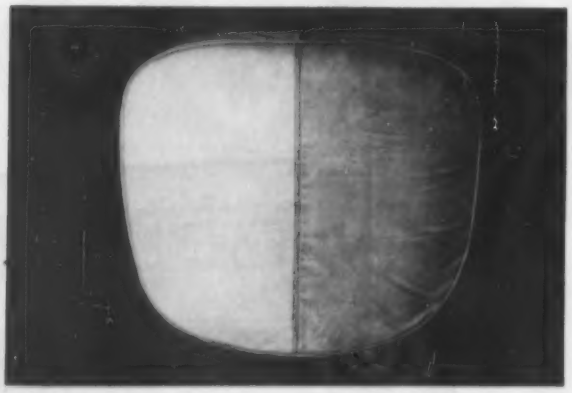
How to get more value for your vinyl-upholstery dollar

(Look for these 4 quality features before you buy)



1. A vinyl coating chemically engineered to stay pliable so you get all the advantages of elastic fabric support. You can be *certain* the vinyl coating will have long-lasting "suppleness" when furniture is upholstered with Du Pont "Fabrilite" elastic-supported vinyl. The plasticizers (softening agents) in "Fabrilite" are an exclusive Du Pont formulation . . . keep "Fabrilite" from stiffening and cracking, even after years of wear.

2. A dry high-slip finish that means greater sitting comfort. Here's a test that dramatically demonstrates the comfort of "Fabrilite." Two equal weights are placed on inclined surfaces that have been covered with "Fabrilite" (left) and ordinary vinyl upholstery (right). See how much farther the weight slides on the high-slip finish of "Fabrilite"! This pleasant dry "feel" of "Fabrilite" makes an important contribution to the comfort of patients and visitors.



3. A dry, soil-resistant surface that stays clean longer . . . is easier to clean. Here's more proof "Fabrilite" gives customers more for their money. Unretouched photo of cushion used continuously for over two months *without washing* shows how much better "Fabrilite" (left half of cushion) resists soiling than ordinary vinyl upholstery (right). The dry surface of "Fabrilite" simply does not collect as much dirt . . . cleans with the whisk of a damp sponge.

4. Snap-back shape retention that ends sagging and wrinkling problems. Be sure your furniture *keeps* its showroom look. These unretouched photographs of chairs exposed to hard service for two years under identical conditions show how "Fabrilite" (on left chair) keeps its unwrinkled appearance longer than ordinary upholstery (right). Elastic-supported "Fabrilite" has both "suppleness" for comfort, and resilience to snap back to its original shape.

You're sure to get these values when you specify furniture upholstered with

DU PONT
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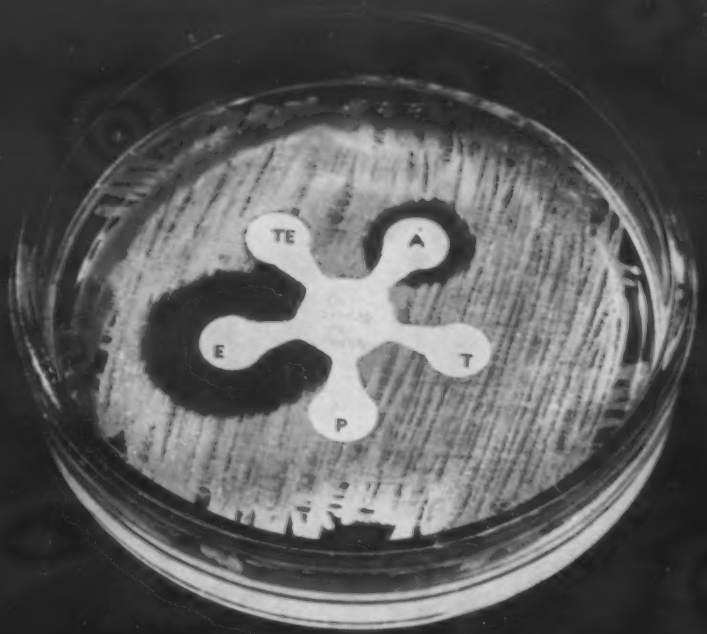

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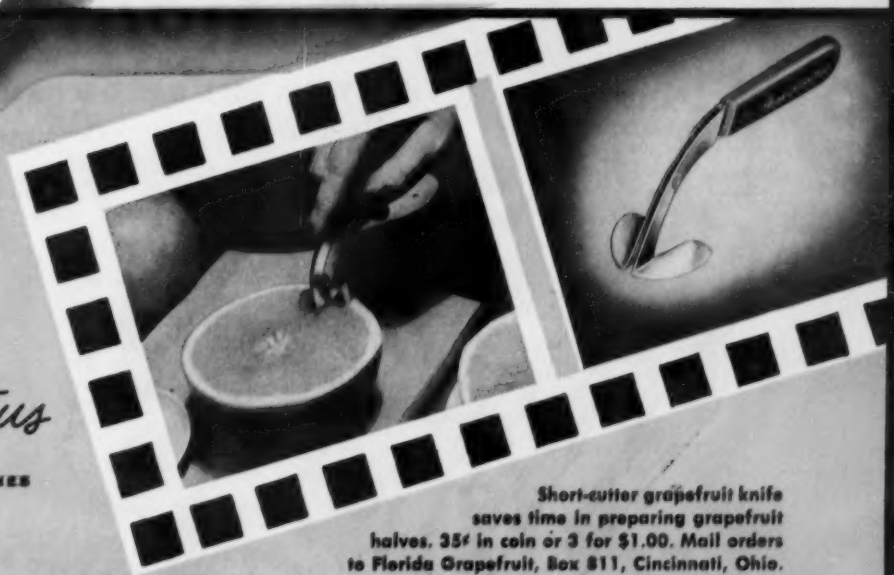

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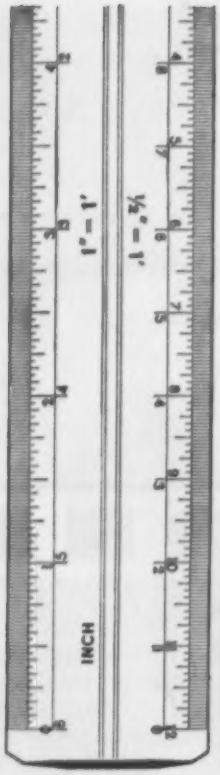

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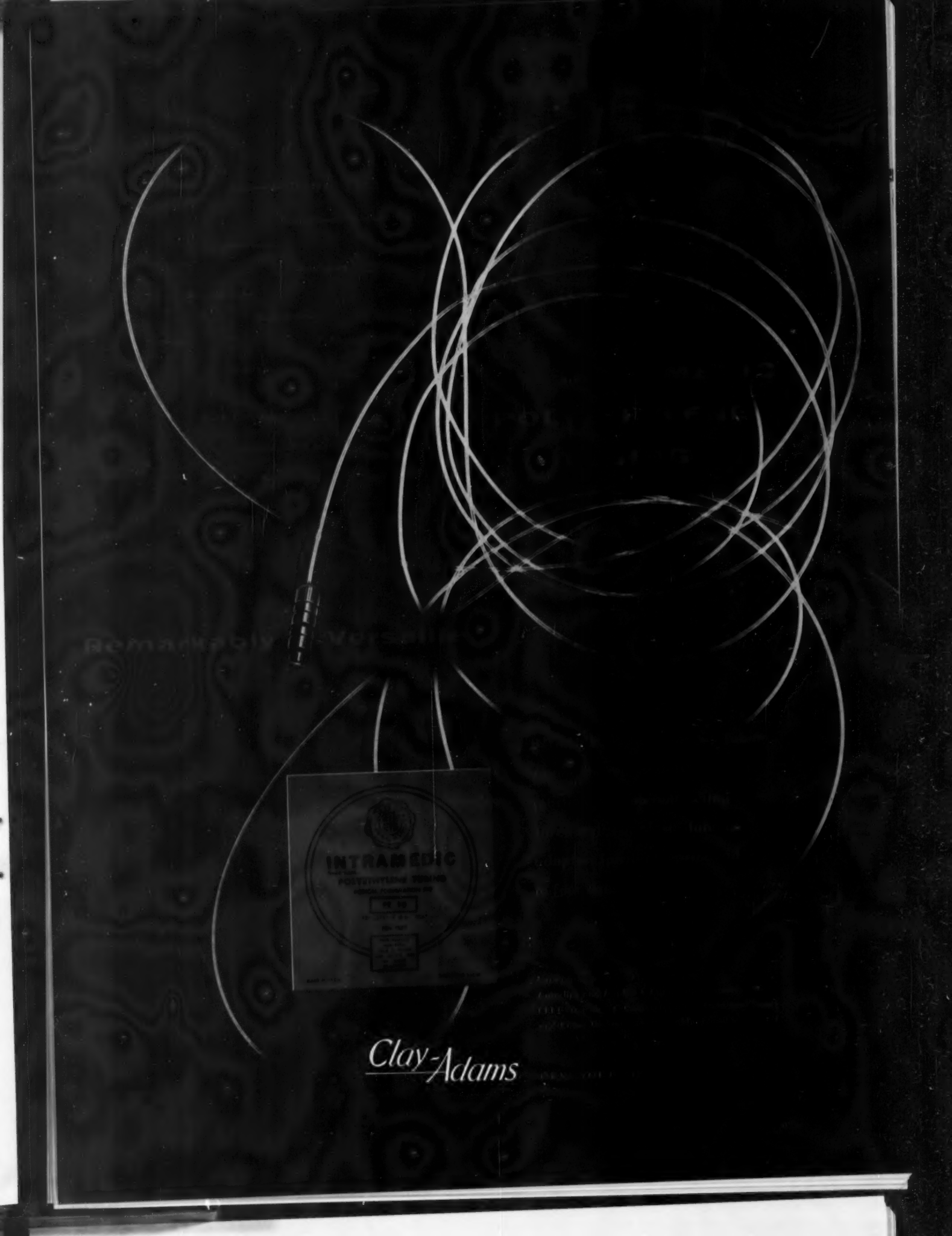
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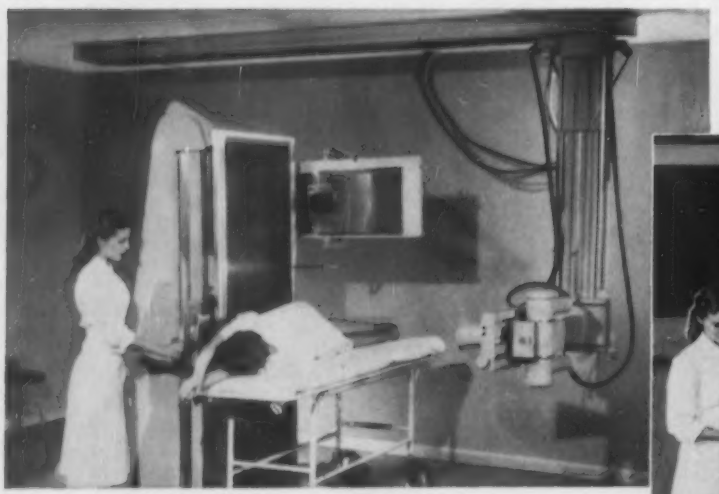
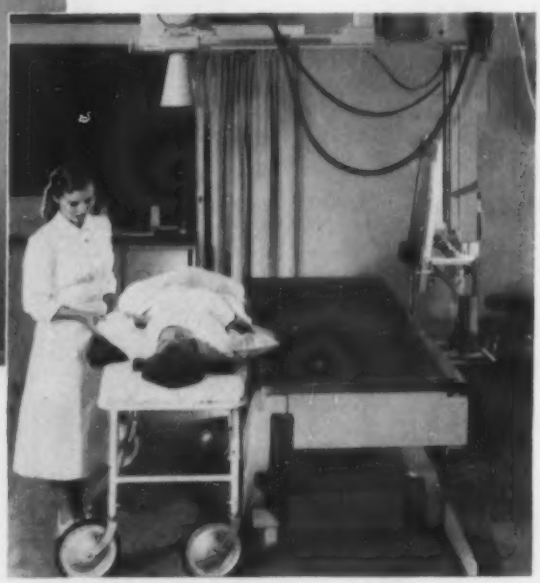
Ask your G-E x-ray representative to show you how the REGENT can add ease and facility to your radiography and fluoroscopy. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wis. for Pub. H31.



Decubitus Bucky radiography of cart patient can be done routinely at focal-film distances up to 60 inches. REGENT is also available with conventional tube stand, floor-to-ceiling or platform mounted.

REGENT'S overhead tube support facilitates hospital-cart radiography—tube can be positioned well beyond table front.



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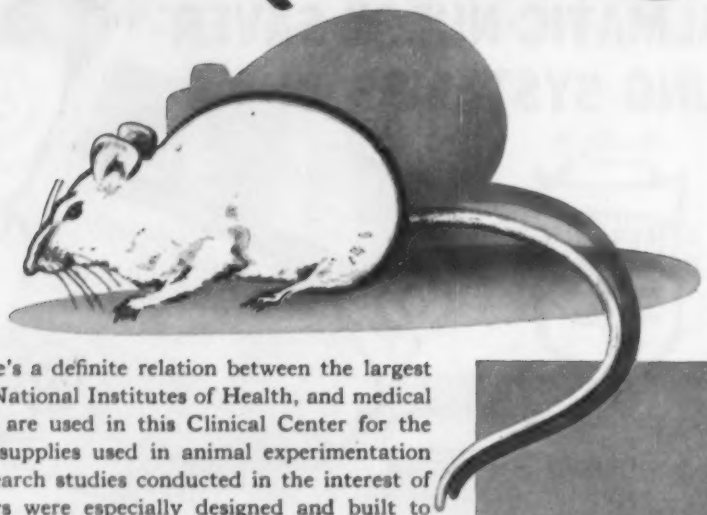

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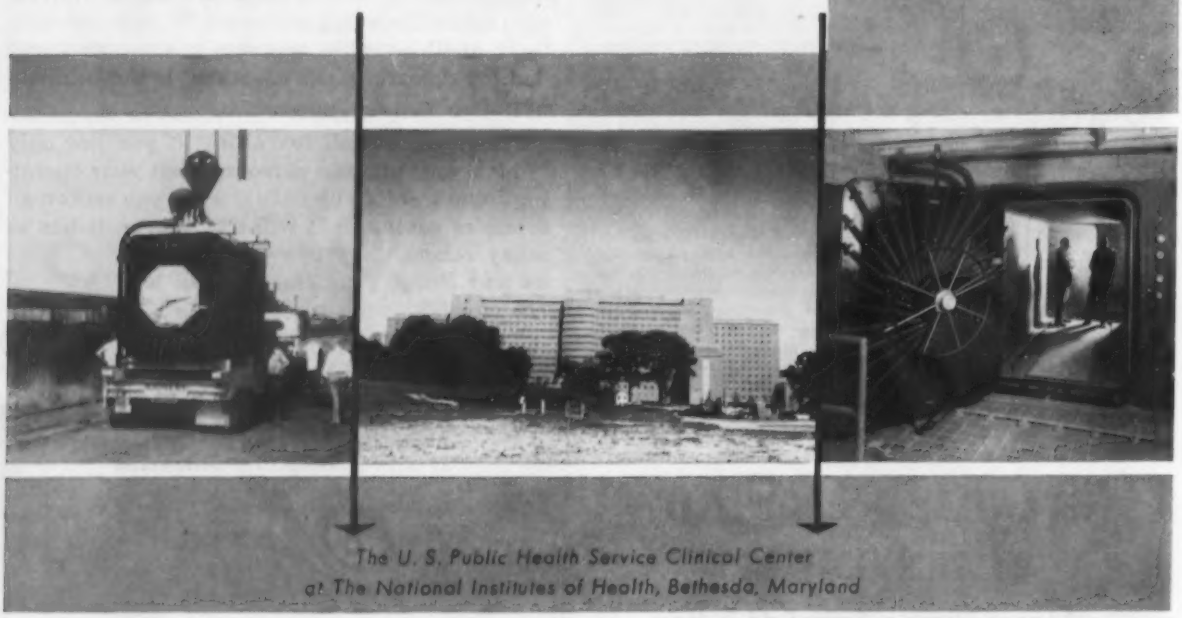

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Purchasing Coal

Question: When the state law requires us to advertise for bids for the purchase of coal, what requirements should we include and how can we check during the year on the quality received?—J.B., Mo.

ANSWER: Coal for a public institution should be purchased under a rigid specification based upon thermal units.

The basis of the award of the coal contract is: In the event all the requirements of the specifications are complied with, the coal contract should be awarded to the bidder offering the greatest number of British thermal units for 1 cent.

The conditions and special requirements under which proposals should be made are contained in the following summary:

Specify the kind, size consist, preparation and minimum characteristics of the coal desired and best adapted to the furnace.

Obtain competitive bidding by advertising and mailing the solicitation of bids to a number of vendors.

Require vendors to guarantee the physical characteristics of the coal they propose to furnish and to specify the source of origin.

Provide for periodical sampling and testing of the coal delivered.

Provide for assessment of penalties for failure to meet the guaranteed characteristics—within the tolerance—and the granting of premiums for exceeding them.

Payment for the coal delivered should be on the basis of the heat value of the coal as determined by analysis.—EDWIN A. LEDERER, *director of purchases, Chicago public schools.*

Hospitals Own Instruments

Question: A group of doctors in this area is interested in gathering information concerning hospital ownership for surgical instruments for use by doctors just entering practice. It would be of value to us to know what the usual procedure is among hospitals today.—S.I., Wash.

ANSWER: Years ago, teaching hospitals and others with large intern and resident staffs started the practice of furnishing surgical instruments, as a means of standardizing teaching practice and setups in the operating room. Prior to that time, surgeons for the most part owned their own instruments. In recent years, hospital ownership of surgical instruments has been increasingly prevalent, in hospitals of all sizes, and today most hospitals furnish standard instruments for all the usual hospital procedures. For highly specialized procedures requiring special instruments, it is still common for such instruments to be owned and furnished by the surgeon instead of the hospital.

Laundry Chutes

Question: Do you have information on the installation of laundry chutes in hospitals? Do most hospitals have such installations? What particular problems or features should be emphasized in connection with hospital laundry chutes?—K.A.H., Ont.

ANSWER: Nearly every new hospital built in the United States since the war has been equipped with one or more laundry chutes. Most often, these have been the stainless steel variety, equipped with fire sprinkler heads.

In many hospitals, the separation of operating room linen and other contaminated ordinary laundry from the nursing units necessitates some use of hampers and trucks in addition to the laundry chute. In a few instances, this problem may be solved in the original plan by providing a separate laundry chute for the operating room suite.

Visitors Aren't Neat

Question: How can we keep visitors from putting soft drink bottles on the furniture and leaving them around in waiting rooms and solariums?—R.A.K., Ariz.

ANSWER: You can't. It may help to keep containers handy in which visitors may dispose of these items, and to post signs asking them to keep these areas neat. However, frequent checks by housekeeping maids or porters are probably the only way to make certain the waiting rooms and solariums will appear neat and "cleaned up" at all times.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital Waterville, Maine, and others.

Records Are Staff Problem

Question: More than a year ago, our hospital received provisional approval from the Joint Commission on Accreditation of Hospitals. Time has gone on, however, and our medical staff has not followed all the commission's recommendations vigorously, to the point of getting medical records completely up to date, and reorganizing the staff as it should be done. We have been reading about the "medical audit" and wonder if such a program would help us with our accreditation problem.—J.C., N.D.

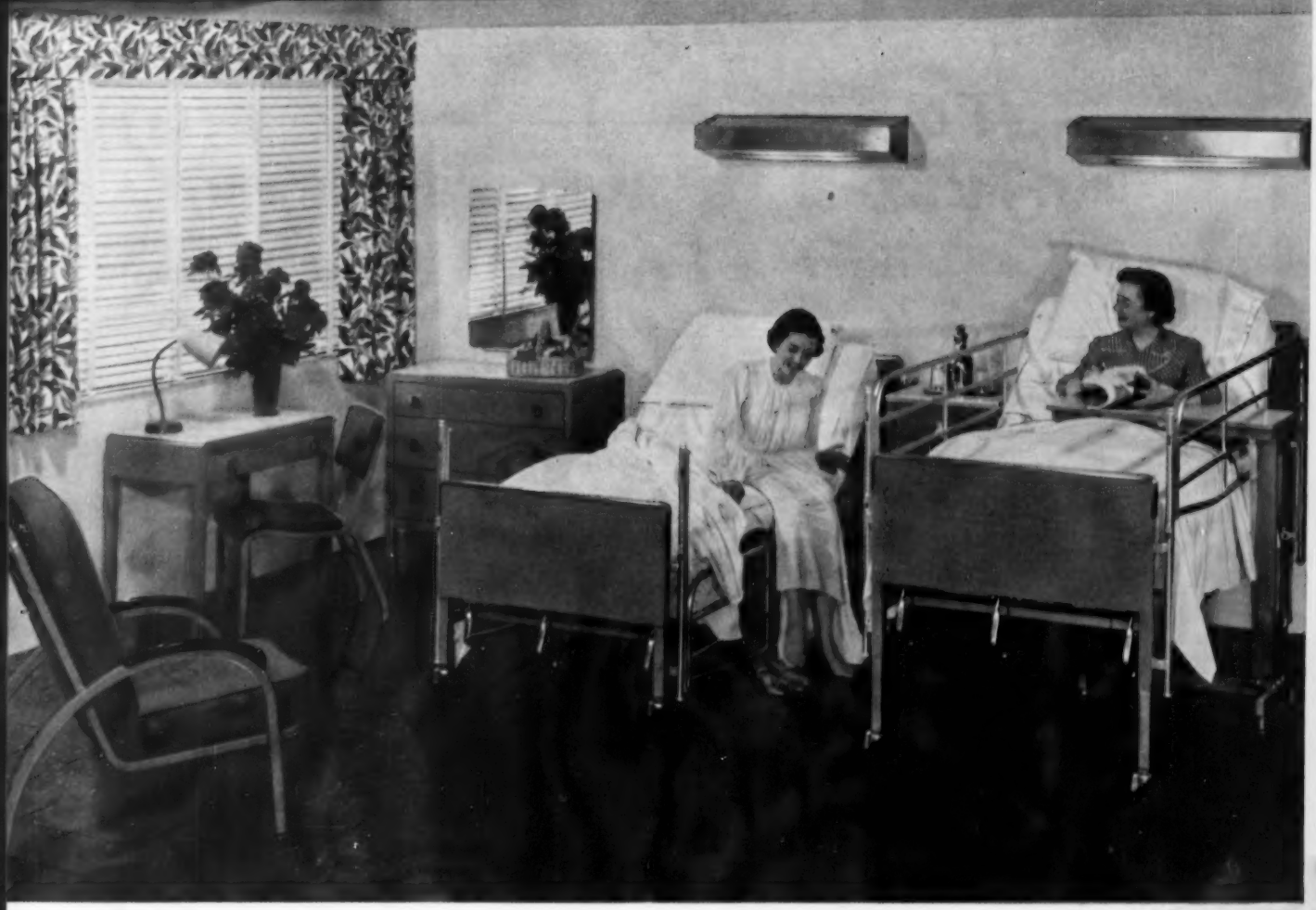
ANSWER: Certainly a medical audit by a properly qualified consultant would reveal any deficiencies in detail and point the way to solution, but it should be borne in mind that no outside consultant can do the job unless the staff members themselves are interested in maintaining accredited status and improving medical standards. For a detailed report on the nature of the medical audit, its procedures and results, see page 106 of this issue.

Eliminating Odors

Question: We have a persistent problem of "hospital odor" in a number of areas—especially in our nursing units, but also in the lobby, emergency room and other areas visited by the public. Are successful technics available for ridding these areas of characteristic hospital odors?—D.E.C., Ont.

ANSWER: The first rule for ridding the hospital of institutional odors is to establish and enforce rigid standards of cleanliness, and make certain adequate ventilation is provided in all areas where unpleasant odors are likely to originate. In older buildings, ventilation problems may exist, and it may be worth while to call in a ventilating engineer to survey the hospital and suggest measures for solution of the problem.

In addition to these prophylactic measures, a number of manufacturers now furnish materials that may be used to eliminate or mask unpleasant odors in extremely troublesome areas.



LOS ANGELES' FAMOUS

Cedars of Lebanon Hospital

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The concept of a new Maternity and Pediatrics Building for world-famous Cedars of Lebanon Hospital demanded furnishings and equipment that would not only be the last word in efficiency and practicality, but would provide color, warmth and beauty as well. The selection was Simmons—of course.

Quality of workmanship and materials has been a Simmons byword for over 30 years. No other line of hospital equipment can match Simmons for efficiency and versatility—kept constantly up-to-date through ceaseless testing under actual hospital conditions. Yet, as shown above, the color, warmth and styling of Simmons Furniture form a sharp contrast to the cold institutional atmosphere usually associated with the word "hospital."

If you're planning new construction or refurnishing, see your Simmons Dealer, or write the nearest Simmons office for helpful advice.

Room shown above is from the new Maternity and Pediatrics Building, Cedars of Lebanon Hospital, which has been furnished completely by Simmons. Furniture is Simmons "152" Series in Silver Mist. Beds are versatile Simmons Vari-Hite, equipped with 3-crank springs and safety sides.

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Tilting Beds. Aluminum— tilts either end.	**Service Exchange.** A generous allowance on the trade-in of an old X-P for a new X-P.	**Foam Mattress** and Vinyl plastic cover to fit.
Foam Mattress and vinyl plastic cover to fit Incubator or Tilting Bed.	**AND,** as always, good service if you'll write us the details air mail. QUICK,—too.	**AND,** as always, good service if you'll write us the details air mail. QUICK,—too.
New Style Thermometer— metal armored—rugged—to replace old style Panels and cut maintenance costs.		
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AND, as always, good service if you'll write us the details air mail. QUICK,—too.		

THE WINNER of our "Indian Cobra Contest" will be announced in this magazine next month. Many fine answers received. Thank you.

Details and prices are available on any of the above

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LEGISLATIVE LINE-UP

President Eisenhower may get part of his hospital-medical program enacted by Congress this year, but he won't get all of it without two or three resounding battles on Capitol Hill.

This is apparent even before hearings start on the major bills. Several of the hearings are expected to get under way this month. Others won't start until April or May. Already the American Medical Association has made its position clear: It supports a great deal of the President's program but is prepared to fight him all-out on reinsurance and, if necessary, on one or two other issues. The American Hospital Association is taking a long time making up its mind on reinsurance, which it supported last year. This may be an indication A.H.A. would like to switch and oppose the bill.

On another controversial bill, for federal guarantee of private mortgages on health facilities, both the A.M.A. and A.H.A. are holding up decision, pending further study. That is not a good omen for the Administration. A.M.A. opposed a somewhat similar bill last year, while A.H.A. avoided taking a direct stand. This year's bill is amended to make it more acceptable to the doctors and the hospitals; the question is whether it has been or could be changed enough.

The bill for health insurance for federal employes wasn't expected to stir up a row, but it has. The A.M.A. supports the principle of this bill, but is watching the details carefully. The A.H.A. would like to support the principle, but is alarmed about what it regards as the de-emphasis of local plans in the Administration bill.

The Administration is proposing a huge, nationwide indemnity plan, including limited outpatient care and a $2500 maximum catastrophic coverage. The A.H.A. is fearful that a preponderance of the 1,800,000 eligible U.S. employes will come in under this tent, thereby wrecking many local plans and taking control out of the hands of physicians and hospitals.

Hospital people already have made their position clear to Senate and House committees, and there is a possibility the bill can be changed enough to eliminate most of the controversy.

The position of A.M.A. and A.H.A. on an improved program for medical care of indigents likewise is uncertain. The A.H.A. said it approved the plan, "if the program is in accord with basic American Hospital Association policy," principally the requirement of maximum local administration and control. The A.M.A. is uncertain on this and is taking more time to study the implications.

The two associations, whose combined opposition probably could block any legislation, have agreed to support a number of the Eisenhower bills. Other Administration bills have the support of one, with a "no-action" position taken by the other. These include a new program of mental health grants to improve care, to stimulate research, and to train more personnel; the training of more practical (and possibly graduate) nurses; a new system for allocating U.S. public health grants to the states; more research in water and air pollution, and an improvement in status and survivor benefits for the U.S. Public Health Service.

NURSES' TRAINING AID

Because only about 26 per cent of the graduate nurses who are teachers or administrators in hospitals have had specialized training for these posts, the Administration wants to set up a program of two-year traineeships or scholarships, carrying subsistence stipends as well as tuition and other school expenses.

On the recommendation of the Surgeon General of Public Health Service, Congress would decide how much money to put into this program.

Some of the traineeships would be in Public Health Service institutions, but the U.S. would also finance students in public and nonprofit hospitals and schools. This is acceptable to the A.M.A., but the A.H.A. wants more time to study it. Here the hospital group made a distinction: it is opposed to grants for scholarships to undergraduate nurses, it is uncertain about graduate nurses, but it approves the idea of training more practical nurses.

The recommendation for practical nurses, also approved by the A.M.A., is to set up a five-year program of grants to states to extend and improve this type of training. For the first two years the states would put up 25 per cent of the cost, and for the last three, 50 per cent. Funds would be used for cost of instruction and administration.

Assuming a fair number of lawmakers follow the lead of the A.M.A. and the A.H.A., the program for training practical nurses will get through Congress, but the other nurse-aid plans will not.

SURPLUS MATERIAL

A move is under way to make the Defense Department observe the spirit of the statute that says surplus U.S. material should be offered free to hospitals and schools if it cannot be sold for a substantial amount of money.

For several years the law has been on the books, and has resulted in turning over to states or nonprofit organizations many millions of dollars in items no longer needed by the government. Defense Department, however, has a new regulation requiring that surplus material be listed in a "capital account," from which it is sold to the highest bidder at prices said to average less than 5 per cent of acquisition costs.

Leading the fight to force Defense Department to get in line with other federal agencies is Rep. John McCormack of Massachusetts, House floor leader for the Democrats. Mr. McCormack is also chairman of a government operations subcommittee that has completed hearings on a bill aimed at correcting the situation.

American Hospital Association is supporting the bill, as is the National Association of State Agencies for Surplus Property. At the hearing Mr. McCormack said governors of six states had telegraphed their support—Kansas, Nevada, Michigan, Massachusetts, Maine and Florida.

The legislation would require that Defense and all other federal departments and agencies release to states or other nonprofit organizations surpluses that will not bring substantial return. It would also simplify transfer of title to facilitate movement from federal to other agencies.

NEW HILL-BURTON

Before the end of the fiscal year next June 30 the Division of Hospital Facilities expects to start allocating money to specific projects under the expanded Hill-Burton program. For the present fiscal year Congress has appropriated $21,000,000, which will be available for allocation until July 1, 1956. For the next fiscal year, starting next July 1, the Administration is asking Congress to vote the full amount for this program—$60,000,000. Money will go to help in construction of chronic disease hospitals, diagnostic-treatment centers, nursing homes, and rehabilitation facilities.

Four state plans have now been approved, and individual projects have been submitted to Washington for approval. Five other states are making revisions to bring their plans into line with federal requirements.

The big problem now is to get a large number of state legislatures to change their laws to authorize programs to aid nursing homes and rehabilitation centers. Until this is done the states can't prepare their over-all programs for submission to Washington. Because of this delay, it is expected that a few of the states won't be ready to operate until July or August.

NEW COVER IN COLOR

During these years of rapid advancement in hospital design, operating technics, and business management, one of the most remarkable developments has been the increasing use of color in hospitals. The modern hospital today uses color abundantly in patients' rooms and service areas; color combinations are chosen carefully to soothe the sick, please visitors, and create a pleasant working environment for staff and personnel.

To help report this major trend in hospital practice to its readers, The Modern Hospital next month begins a new service in hospital journalism, introducing a new cover design that will include reproduction in full color of representative buildings, hospital rooms, departments and activities, showing what hospitals are doing with color today.

—The Editors

V.A. HOSPITAL INQUIRY

The hospital field and other interested parties may have more facts and less fire, smoke and confusion about the Veterans Administration. One of the decisions of the new chairman of the House veterans affairs committee is to make a thorough survey of V.A. hospitals.

Rep. Olin Teague (D.-Tex.), the committee chairman, will try to find out all he can about length of stay, construction and maintenance costs, utilization of personnel, and the extent to which nonservice-connected cases are covered by hospitalization insurance and the amount being collected on this insurance by V.A. Mr. Teague also has called for statistics to show, if possible, what effect the revised form 10-P-10 has had on admissions.

The inquiry covers a broad field, and is asking for information that other committees and commissions have sought vainly in the past. However, Mr. Teague now is in a position to bear down on V.A. and its hospital administrators and demand the information he has said he wants.

A dentist, who in only two years in Congress has mastered many of the intricacies of the Veterans Administration hospital system, is chairman of the hospitals subcommittee of the House veterans affairs committee. He is Rep. George S. Long (D.-La.), a brother of the late Sen. Huey Long.

Other members of the committee are Democrats James A. Byrne (Pa.), Leo W. O'Brien (N.Y.), and B. F. Sisk (Calif.) and Republicans Bernard (Pat) Kearney (N.Y.), subcommittee chairman in the last Congress, and William Avery (Kan.) The Long subcommittee has jurisdiction over bills on construction and location of hospitals, on outpatient dental care, and on the right of veterans to medical care.

The subcommittee responsible for bills on presumption of service connection for various illnesses is headed by Rep. W. J. Bryan Dorn (D.-S.C.). Other Democratic members are George Christopher (Mo.) and Charles Diggs Jr. (Mich.), and Republicans E. Keith Thomson (Wyo.) and Paul Fino (N.Y.).

Friends of veterans again are proposing longer presumptive periods for specific diseases.

DR. LETOURNEAU RESIGNS FROM A.H.A. TO ACCEPT N.U. APPOINTMENT

CHICAGO.—Dr. Charles U. LeTourneau has resigned from the American Hospital Association staff to accept an appointment as director of the program in hospital administration at Northwestern University here effective April 1. Dr. Malcolm T. MacEachern, director of the Northwestern program since it was organized in 1943, will remain as honorary director and professor of hospital administration, the university said. Dr. LeTourneau has been secretary of the A.H.A.'s council on professional practice and editor of *Trustee*. He joined the A.H.A. staff in 1951.

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LOOKING AROUND

Good News

IT IS good news to the hospital world that Crayton Mann, administrator of Baptist Hospital, Evansville, Ind., is getting better. Paralyzed as the result of a diving accident last summer, Crayton carried on as administrator from a bed in his own hospital for several months, managing the details of a million-dollar building program, as well as day-to-day operations. Later, he was transferred to the Veterans Administration Hospital at Hines, Ill., where he has been receiving treatment and, it is reported, steadily gaining ground. His return to hospital service is assured, and his courageous spirit assures a distinguished career in hospital administration.

Rich Man, Poor Man

AT A gathering of hospital people we attended not long ago, a visitor from abroad spoke admiringly of the many beautiful new hospitals he had seen in the United States. "But these were all hospitals for rich people," he added thoughtfully. "I should guess that your poor people are not so well provided for."

The suggestion that we have different standards of hospital service for rich and poor was plainly regarded as an alien outrage by some of our most respected hospital leaders. "Here in America," one of them declared, as heads nodded approvingly around the table, "rich and poor alike get exactly the same care!"

Apparently, this pleasant nonsense has been repeated so often by American medical apologists, in support of a do-nothing policy for medical care of indigents, that it is now believed even by those to whom we look for leadership in hospital thought and practice. While it is certainly true that in a few of our medical school hospitals the same doctors may operate on or manage the care of private and ward patients, this does not mean that rich and poor are getting the same care, even in those hospitals. The patient who is operated on by the resident with the chief looking on is not getting the same care as the one who is operated on by the chief with the resident looking on.

Outside our wealthier teaching hospitals, the gap widens. It would appear, for example, that the rich-and-poor-alike savants have overlooked entirely the 750,000 patients in our mental hospitals. Of this huge number, the vast majority are in state institutions, where, according to figures released recently by the National Association for Mental Health, the average cost is $2.70 a day, in contrast to an average of $13.50 in private mental hospitals —a discrepancy that is hard to square with the concept that everybody is getting the same thing.

Also hard to reconcile with the fiction about rich and poor are the facts of life as we have observed them in some of our big city and county hospitals—the 56 bed ward at one great county hospital, for example, where a recent survey revealed a single graduate nurse on duty during the 11 to 7 shift; or the surgical ward we visited not long ago in Harlem, where twenty-odd beds were jammed into a space that was planned for half that many, and the floor was littered with dirty dressings. These hospitals are staffed by the best trained physicians in the world, but this does not alter the grim economic circumstance that prevents them from being little more than huge factories and warehouses for the acutely ill and injured. The same economic facts produce about the same conditions in numberless small city and county infirmaries across the country, with the exception that here the quality of medical care at the top is not so good. Many voluntary hospitals try to provide the same service for all, and a few succeed, but with rates paid by welfare agencies still far below cost in most cases, the result is usually that the rich are getting soaked or the poor neglected, or both.

Finally, the sunny-side-up chorus must ignore the uncounted thousands

of sick poor who don't get to the hospital at all. Nobody knows how many people there are in the United States who fail to get adequate medical care because they can't afford it, but as we pat one another on the back for enrolling 100,000,000 people in hospitalization and medical care insurance plans, we mustn't forget the 60,000,000 who are left out.

Like our leaders, we rejoice in freedom and take pride in the many virtues and accomplishments of private medicine and voluntary hospitals in America. But the greatest safeguard to our medical freedom, as we see it, must be a constant effort to meet the unsolved problem. Our freedom, and our country, are poorly served by pontifical mouthings that ignore the facts and pretend no unsolved problem exists. The man in bed in a grimy ward in Harlem would be better off if our hospital leaders would stop telling him how lucky he is and send somebody in to clean the floor.

Task Ahead

MOVING into its fourth year of operation, the Joint Commission on Accreditation of Hospitals has achieved a stature that its member organizations can be proud of. Approval by the commission has become widely recognized as a badge of hospital respectability among administrators, trustees and physicians. In many communities, too, the general public is beginning to understand the meaning of accreditation—a result that has been achieved, in some cases, by the necessity for conducting commission business in the painful light of full publicity.

For the most part, however, the commission staff has moved forward quietly in the accomplishment of its appointed tasks, conducting its surveys and inspections, compiling the results, and discussing necessary changes and improvements with hospital administrators and medical staff members. Commission standards have been revised in the light of experience. Standards for staff organization and staff meetings, for example, have been clarified, and the standard for consultations has been strengthened, always with the aim of making accreditation standards such that in order to meet them a hospital must not only look good but be good.

If there are many solid accomplishments written into the commission record, however, there are still as many blank pages on which the record is yet to be written. Reports from a number of hospitals that have been surveyed for the commission indicate, for example, that there is still a wide variation in the quality of inspections; one man's careful, conscientious examination of the records may be matched by another's once over lightly, topped off by an afternoon of chatter about medical personalities and good old times in the navy. Inevitably, the result has been that the currency of accreditation fluctuates in value; a hospital with deficiencies may get full or provisional approval, while another with lesser sins but tougher inspection may fail.

The answer to this and the even greater problem of covering the presently accredited hospitals more frequently, and visiting the nonaccredited hospitals that need help most of all, lies in an expanded operation, with many more members on the commission staff and the inspection staffs of the constituent organizations, and enough money to command competent men for these positions and train them thoroughly for their responsibilities.

To do the job, the commission budget may have to be increased—possibly to four or five times its present size. The hospital membership, for one, should be glad to contribute its share. If there are no questions asked when the budget to produce manuals on how to buy canned peaches is doubled, there should be no restrictions at all on the budget for improved standards of medical care.

The Outcasts

WHEN they aren't brooding about the building or the budget, here is a problem for administrators and trustees of well organized hospitals to ponder: How does it profit the community if, through the enforcement of increasingly high medical standards, practice within the hospital gets better and better, while practice outside the hospital gets worse and worse—a circumstance that might easily come to pass if our programs of medical improvement fail to comprehend the situation of the practitioner without hospital privileges?

It is unthinkable, perhaps, that with all their other problems hospital administrators and trustees should assume any responsibility for nonhospital practice, and yet the fact is that the doctor who is dropped from the staff, or who can't qualify for the staff, will still practice medicine in the community. With hospital facilities denied him, he may treat patients who should be in the hospital in his office or at home, instead of turning them over to his colleagues on the attending staff. Or, in association with other underprivileged doctors, he may buy an old residence or apartment building and organize a hospital that is untroubled by such refinements as qualifications, records, staff meetings, consultations and discipline.

What is the responsibility here? Trustees have no legal jurisdiction over the practice of medicine outside their own hospitals, to be sure, and certainly it could be destructive of medical standards generally to return to the old, open staff concept of medical care in the hospital. In recent years, for purposes of space, organization and improvement, many of our better hospitals have been limiting or eliminating the courtesy staff which provided hospital facilities for practitioners in the community who were not qualified for, or did not seek, attending staff appointments. From the standpoint of the individual hospital, this movement to eliminate the courtesy staff may have been necessary and good; from the standpoint of medical care in the community generally, it may have unfortunate results. The needs of the whole community might be served better by the retention of some kind of courtesy or junior or subsidiary staff which would bring a larger number of doctors within the hospital's jurisdiction and discipline, at least for a part of their practices.

The plight of the doctor who is licensed by the state to practice but forbidden by the governing board to practice in the hospital demands consideration. So does the plight of his patients.

Two Lines of Authority Are One Too Many

George Washington's criticism of hospitals—

"No principal director and no subordination among surgeons"

— is still valid and still a basic cause of conflict in hospitals today

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CERTAIN organizational problems distinctive to hospitals become apparent when they are viewed alongside other complex human organizations. These distinctive features provide a set of constantly recurring problems to which people working in hospitals must adapt. It is proposed here to analyze the bases of such organizational problems and to indicate the dilemmas they entail for the administration of both lay and professional hospital personnel.

George Washington once reported, after a hospital inspection, that he had found no principal director, and no subordination among the surgeons. He expressed his belief that this led to disputes which would continue until the hospital was reduced to some system. This might still be considered a valid capsule criticism of many modern hospitals.

Understanding the details which underlie such criticism requires study of the human (social) matrix of hospital administration. As a sociologist, I have undertaken such study over a period of years in a variety of hospitals in several regions of the United States. I have had, in addition, several years of military service in hospital administration. Research and some practical experience therefore underlie this sociological report on hospitals.

ANALYSIS OF HOSPITAL STRUCTURE

Basically, a hospital may be viewed as an organization at cross-purposes with itself. It is the kind of human institution about which people constantly complain that they are caught "in the middle." What they are caught in the middle of is a direct function of what we shall call the basic duality of hospitals.

A clue to the nature of this duality is provided by the statement that one frequently hears in hospitals—"The big thing here is the difference between what they say we do and what we actually do." A closer look at this difference brings us closer to the operating problems of hospital administration.

Let us start with the system of controls, the hierarchy of authority, through which a hospital operates. Here are found very great differences between what the hospital says it does and what it actually does.

Take, for instance, the formal organization charts which many hospitals believe reflect a true picture of their pattern of operation. A comparison of the patterns indicated on such charts with the observed relationships among people actually working in the hospital reveals that usually the hospital organization chart portrays a complex system of administrative controls over lay people. Thus, there is the hierarchy from board of trustees to hospital administrator to department heads to various categories of hospital workers. Hospitals vary in the degree to which the authority and responsibility at each level, and the channels of communication among them, are explicitly developed. But a closer look at an operating hospital reveals that this is far too simple a portrayal of its actual organization for work. The primary difference involves the rôle of professional persons —especially the physicians. There is almost no administrative routine established in hospitals which cannot be (and frequently is) abrogated or countermanded by a physician claiming medical emergency—or by anyone acting for the physician and similarly claiming medical necessity. Upon close observation it is found that the actual authority of the medical man in the hospital is very great indeed. Although the conventional organization chart portrays the position of the medical staff as outside the line of authority, we observed physicians to be exerting power throughout the hospital structure at all levels—upon nurses, ward personnel, upon patients, and even (where physicians were trustees) directly upon administrators themselves.

Thus, two main lines of authority —lay and professional—exist in the hospital. And there are sectors of the hospital which may not clearly be assigned to either, and in which the authority of both may overlap. We have called these the "hybrid areas"—and they are typically represented by pharmacy, pathology, x-ray, admissions, and medical records. These are mixtures of lay and professional competence and authority.

AUTHORITY MAY OVERLAP

This duality of controls is a product of the complexity of hospital organization—a complexity shared by other human structures (*i.e.* universities) where professional competence is exercised in a matrix of lay administration. In essence, it involves the attempt to handle two different prin-

ciples of authority within one institution. The work of Max Weber[1] provides us with ideas for analyzing and understanding such complexity. The authority vested in (exercised by) lay administration is of a type familiar to us all. It is close to what Weber has classically described as bureaucratic authority, functioning in a clearly defined hierarchy with "packets" of authority and prestige prescribed for each level. But the problem for the hospital is that the authority of the bureaucrat confronts that of the medical professional, who represents what Weber has called charismatic authority. This sociological term, borrowed from theology, and meaning literally "gift of grace" represents the kind of authority which a person exercises by reason of having a set of followers who attribute special powers to him. By virtue of these special powers attributed to him he is held somewhat in awe. Weber recognized that the physician was a charismatic person.[2] One of the primary characteristics of charisma is that it is defiant of administrative regulation. Possessors of charisma resist being encompassed in bureaucratic organization. It is, in these terms, the special problem of the hospital that it is an administrative structure which must contain and regulate charismatic professional persons who are defiant of lay regulation. Thus, both administrators and physicians are authoritative figures, but for different (and basically conflicting) reasons. This provides, so to speak, a built-in conflict situation for hospital administration.

CONFLICT BETWEEN SYSTEMS

This problem may be seen in another way—as a conflict between two systems of status in the hospital. The ideas of Chester Barnard[3] are useful in understanding this. Barnard has noted that two kinds of status may be found in human organizations. One of these he calls "scalar" status—or the status inherent in a position within some hierarchical system. High rank in an organization and high status thus coincide. The other form of status he calls "functional." Such status inheres in certain kinds of work, regardless of the position of the worker in a ranked system. Thus, in the hospital, administration represents a system of scalar status, and the physicians carry high functional status. Orders normally come from those whose status is higher than the recipient of the orders. Hospital personnel find themselves receiving orders from carriers of both forms of status—from the administrative side whose "right" to "boss" them is explicitly recognized, and from the physicians whose "right" to "boss" them is not so clearly recognized but is just as keenly experienced. Such orders often reflect the conflicts which inhere in the dual status system.

A dual system of values, expressing these conflicts, pervades the hospital. A hospital is, of course, many things: a place where the sick are cared for and treated, a place to which physicians bring their patients, a hotel, a laundry, a healing institution, a business organization. These many "purposes" of a hospital are rarely subsumed under any single "master symbol." Rather, these many activities tend to be justified, by persons working within hospitals, in terms of two dominant values or symbols: "money" and "service." And frequently these are expressed as considerations of money *versus* service (or vice versa). This means, in brief, that a hospital is not quite sure of the kind of organization that it is, or should be. Is it a service institution or a business institution? Or something of each? Hospitals are faced with the need to come as close to balancing their budgets as possible while being sensitively aware of their task of serving the health needs of a public which includes those who cannot or will not pay for their care.

In the main, administration is forced to focus upon the contingencies of fiscal survival and the physician more often appears as the person dedicated to the service aspect of hospitals. The fact that administrators and physicians often switch sides tends to point up the reality of this dichotomy of values. The employes of the hospital who have to mediate between the often conflicting demands of "money" or "service" are again confronted with a conflict situation which is built into the hospital.

All of this makes the hospital a peculiar form of power structure. Its distinctive aspects may readily be seen if we compare an "idealized" picture of the power structure of an industrial plant with a similarly idealized picture of the "flow" of power within a hospital.

Consider industry. Here, in a nonunionized plant, we find the flow of authority from management to the worker. Where a union is present in the plant the workers are able to exert counterpressures upon management. Staff members ordinarily act in an advisory capacity to top management, although in a functionally organized plant they may exert specific authority over particular segments of the plant organization. The crucially important productive work is performed at the worker level, low in the status hierarchy. Characteristically, conflict in such an organization appears as worker resistance to management.

Crucial differences appear when we consider the power structure of a hospital. We have the similar "line" of authority from management to the worker, with little union-organization resistance in hospitals. But, at the staff level, the physicians do not act merely in a passive advisory capacity. They intervene actively and powerfully throughout the structure, exerting power upon hospital operating personnel, defiant of administrative regulation, and, where they are members of boards of trustees, are able directly to control "top management" itself. Furthermore, it is at the staff level—the high status level of the physicians—that the crucially important productive work of this institution is performed. And it is here, characteristically, in hospitals that we find the important resistances to management (administration) generated. This distinctive aspect of the hospital power structure highlights the problems of hospital administration.

ILLUSTRATIVE CASES

Such basic problems appear in many guises and in many parts of the hospital. They represent a complex interweaving of the controls, status systems, and values which have been described.

The kinds of crucial problems which may arise between lay and professional people in hospitals are illustrated by the following case. A medical director readily admitted that he was so discontented with his job

[1] An eminent German social scientist who died in 1920.

[2] A nursing Sister to whom this term was explained said, "Oh yes, I know what you mean. We call it the Jehovah complex!"

[3] Barnard has combined a successful career as an industrial executive with insightful analyses of industrial organization.

that he was prepared to resign. In fact, he showed us his letter of resignation which he kept on hand in his desk. He gave as the main reason for his discontent in the hospital the fact that he, a medical director who was a physician, was under the immediate supervision of a hospital administrator who was a layman. It was the opinion of this medical director that laymen simply did not know enough about the basic things which were involved in hospitals to do such a job adequately. As he said, "You cannot put a layman over a doctor in a hospital and have it work." He stated that not only he but other physicians in the hospital felt that this was an unworkable relationship. Furthermore, he quite explicitly indicated the belief that his job involved him in something of a status dilemma. He felt himself caught between the requirements of administration and his rôle as a physician, and said that he no longer knew for certain whether he was a physician or an administrator. This case quite clearly reveals the dilemmas which may be experienced by those charged with mediating between these two systems—the administrative and the professional.

PHYSICIANS BREAK RULES

In another case, an elevator man reported a hospital rule stating that there should be no smoking in the elevator. When some physicians had entered the elevator while smoking he informed them of this rule. These physicians had been extremely angry and had reported him to the director of the hospital. He had been summoned to the director's office and reprimanded for trying to give orders to the physicians. Here is a case where the charismatic person of the physician was somewhat inviolate in the face of fairly legitimate lay regulations.

The medical record librarian reveals another kind of dilemma-situation along another kind of axis. This lay person, who is charged with approval of the contents and format of medical records, often has to use what we have called a system of indirect sanctions to effect her job. This is a kind of adaptive behavior which works more or less as follows: Instead of giving physicians a direct order concerning the charts she tells them that unless they do thus and so the reputation of the hospital will suffer, especially at the next inspection.

This use of indirect sanctions by appealing, not to the rules and regulations which give one the right to give the order, but rather to the value system of the dominant person (here the physician), is also clearly revealed in the case of a laundryman. He said that he never had any trouble in the hospital. Whenever he needed something he simply told the person from whom he wanted it that he was asking for what the patients needed. Thus, no direct order is given. Rather, there is an attempt to motivate the person to cooperate in terms of his own value system.

Or, take the case of an old pharmacist who made explicit and expert use of the dual conflict of authority within hospitals at a time when his pharmacy was to be moved to a new place in the hospital. What he had done was simply to play both sides against each other by going and saying to one side, "Don't you think it would be splendid if my pharmacy were in such-and-such a place?" Upon receiving a noncommittal "Yes" he would immediately go to the other side and say, "I have been told by Doctor So-and-So that my pharmacy should be in such and such a place." He then interpreted demurrers by the hospital administration as wanton disregard of professional opinion and wisdom.

It is pertinent to add that this pharmacist actually sewed up the entire system by appealing directly to members of the board of trustees in this fashion. He would visit their homes, bringing medicine for them or their children, and solicit their approval for the place he wanted his pharmacy moved. He would then tell members of both the medical staff and hospital administration that the board of trustees, the ultimate source of authority in the hospital, had suggested a good place for his pharmacy. This old-timer, with 40-odd years of hospital pharmacy experience, revealed a very acute manner of exploiting the divided authority system of the hospital to achieve precisely what he wanted. The result of two bosses for him was independence.

Another problem was reported by the chief of a pathology service who said that every physician in the hospital was a boss for his technicians. They claimed to know what the lab reports were supposed to contain, how much time analyses of various sorts would require, and which methods of analysis should best be used. The girls were constantly badgered to be quicker and more accurate. He felt that every physician in the hospital was a competing expert for his job as chief of the pathology service. Here is a point where lay and professional competence overlap to the confusion of the working personnel.

In still another case we talked with the registrar of a Veterans Administration hospital. He also reported himself as being "in the middle" and went on to add that he was really caught between the demands of the physicians in the hospital and the administrative requirements of operating the hospital. He was, in fact, caught in the classical conflict between lay and professional contingencies in the hospital, especially over the matter of the availability of beds. Administration wanted to adhere to the directives concerning criteria and categories of admission and discharge. Physicians wanted beds occupied by cases that were medically and professionally interesting. Here again there was a clear-cut conflict between the demands of the administrative and professional components of the system and this registrar, mediating between the two, stated the classical dilemma quite clearly, of being "caught in the middle."

"MONEY" VS. "SERVICE"

The problems of admissions offices reveal the confusions caused by the hospital's duality of values. Here, the demands of "money" and "service" are often in conflict for operating personnel and plainly reveal the ambivalence of the hospital as to whether it is a "service" or a "business" institution. This is certainly the case where the hospital is involved in the collection of money. Hospitals are urgent, yet apologetic, about the question of collections. The "front office" (the admissions office) is often caught in the cross-fire of these feelings of urgency and apology. For example, an admitting officer in one of the hospitals told us of her problem of assigning a private room to a man of uncertain means who was moribund. She said that almost against her better judgment she had assigned him a private room. He died soon after and she was very glad that she had done so. But just the same, she said, she was immensely relieved when his wife came in and paid the hospital bill immediately after his death. Here again we see clearly the dilemma of a person who is weighing equally important humanitarian

and fiscal considerations against each other. It is perhaps necessary to point out that there may be no ideal solutions to this kind of problem. This may be a kind of recurrent conflict which is, so to speak, endemic to the hospital as a human organization. Administrators who understand this are better equipped to deal with the strains of their organizations.

This conflict between fiscal and humanitarian demands, as they were interpreted by two different persons in positions of authority, made for a constant duel in one hospital that was observed. They were both persons high in administration—one with training as a nurse, the other with training in business administration. Neither was clearly assigned a position superior to the other. Each constantly berated the other. The administrator with training as a nurse stressed the cold, heartless inhumanity of the business manager, who, she said, tried to screen patients entirely in terms of whether or not they could pay. The business manager complained of the idle, welfare orientation of the nurse, saying that if she had her way she would have the hospital filled with local indigents (a Skid Row was quite near) and they'd have to close their doors in bankruptcy. The conflict between these two for the position of authority was so great that there did exist in fact two organization charts. One, which was more or less publicly distributed, showed the nursing administrator as chief of the hospital. The other, privately distributed but adhered to by the trustees of the hospital, showed the business manager as the "boss" of the hospital.

There are many other problems which seem to be rooted in the peculiarities of hospital organization. Certainly many of the personnel problems faced by hospital administration appear to be more acutely difficult than those faced by administrators of other kinds of organizations. For example, certain hospitals which we observed could have been characterized as "weeping organizations." As a kind of bitter jest we could have established a "weeping index" in which the copiousness of tears shed by members (usually women) of the hospital was some measure of the effectiveness of its organization.

There are several important reasons for this, all of which the hospital must realize, as it must also realize that none of these is susceptible to magic solution. One of these, for example, is that the hospital is a structure of what we have called "blocked mobility." That is, the skills which are developed in one small component of the hospital, for example x-ray or pathology or housekeeping or admissions, are not readily transferrable to other departments. When the question of promotion to another department comes up, persons within the hospital who merit consideration often do not actually possess the skills needed to occupy the new position. In addition to this their skills continue to be required in their old department and very often department heads who have trained their personnel may resist their transfer to other parts of the hospital. This problem of "blocked mobility" is a constant source of frustration for hospital employes. Frequently, the only way to rise in the hospital structure is to leave the hospital, secure outside training, and then return at a higher level of status and competence. This means that a hospital cannot offer many of the same incentives of continuous promotion to its employes as can other institutions.

There is, of course, upward mobility available within the hospital. But some of it is of a peculiar kind and involves particularly difficult problems of interprofessional competition. For example, if we look at a hospital as a total number of a certain set of functions, or operations, some of which have high prestige and others low, we find very often that professional (or subprofessional) groups within the hospital try to improve their status by taking on some of the functions of the occupation above them in the prestige scale,

IOWA HOSPITALS FILE SUIT FOR CLARIFICATION OF RIGHTS

DES MOINES, IOWA.—The Iowa Hospital Association and 28 member hospitals filed suit in district court here last month, charging the Iowa State Board of Medical Examiners and the Iowa Association of Pathologists had entered into an illegal conspiracy to deny hospitals the right to charge for laboratory services. The petition asked the court to declare:

1. That the ownership, operation and maintenance of laboratory facilities are an integral part of the lawful activities of a hospital, and that hospitals may charge and bill for laboratory services as they have done in the past.

2. That nonprofit charitable hospitals have the right to employ pathologists on the same terms and conditions as they are now and always have been employed, and that defendants be restrained from interfering with pathologists in carrying out and performing their legal contracts with hospitals.

3. That defendants be restrained from interfering with plaintiffs (hospitals) in the maintenance and operation of their laboratory facilities in the same manner as hospitals have always operated, including the right to charge for and collect laboratory fees.

Filing of the petition culminated a year-long controversy between Iowa hospitals and doctors, touched off in February 1954 when the state attorney general declared, in an opinion solicited by the State Board of Medical Examiners, that hospitals employing pathologists and radiologists were practicing medicine illegally.

Immediately following announcement that the hospitals' petition had been filed in district court, Dr. Walter Abbott, chairman of the state medical society's committee on hospital relations, declared the suit was a "smear on doctors" and would cause ill feeling between doctors and hospitals.

In contrast, the *Des Moines Register* said in an editorial: "The Iowa Hospital Association made a wise decision by taking to court the dispute over operation of pathology and x-ray departments in hospitals. The hospital association took the initiative in court action, but it was the medical specialists who took the initiative on this entire issue. The pathology and x-ray departments are being operated essentially as they have been for 30

at the same time trying to drop off operations that are lowest in their own prestige scale. This has been true, for example, of the relationships among nurse's aides, nurses and physicians. The professionalization of nurses has included their taking over functions which previously were the physician's prerogative alone—for example, the emphasis upon the rôle of the nurse on the therapeutic team. In their turn the nurse's aides have attempted to focus upon basic nursing operations—some of which the nurses have been only too happy to relinquish as they themselves moved upward.

We have here a kind of dynamic relationship among members of various professions (or occupations) within the hospital which involves basic competition regarding the use of their skills and of certain functions which are assigned to them. This particular kind of competition is, of course, often disrupting to organizational stability. Frequently we find that the reapportioning of functions does not solve the conflict but simply changes its place. For example, the Veterans Administration in one hospital met the demands of the nurses by assigning some of their lower level functions to the attendants in the hospital. Within a short time, however, the conflict had shifted from the nurses to the attendants who were trying to drop some of their lower level functions into the hands of the janitors. In consequence, we frequently have within hospitals a kind of dynamic balance involving the functions of physicians, nurses, practical nurses, aides, maids and janitors in which the symbolic bedpan gets passed from one to the other. Removing odious functions from one occupation assuages it temporarily. We soon find, however, that another occupation is trying to get rid of the invidious task.

This pattern is often complicated by explicit efforts to "improve" the lower echelons through training, pay raises, raising standards of selection and performance, and so on. Such efforts tend to hasten and augment the upward drive of subordinate groups. The superiors who set about to improve their "help" may find themselves facing competitors. Thus, a successful program of recruitment and training of psychiatric aides may frighten nurses into formal reiterations that psychiatric aides perform nursing functions and should be controlled by nurses. These are some of the problems entailed by the peculiar nature of hospital upward mobility.

PROFESSIONALIZATION

All of this points up the fact that a hospital is a seed-bed of professionalization. This makes for special kinds of motivation, and provides peculiar personnel problems. It is of help to hospitals that some persons who find satisfaction in the rôle and prestige of being professionals may be less concerned with the salaries of their jobs. Laboratory technicians, aides, medical record librarians, nurses—all these groups are striving toward recognition as professionals—striving for secure organization around special sets of skills, recognition by other occupations of their changed status, and increased prestige. It is important that the significant organizations of workers in hospitals are not unions demanding higher pay, but proto-professional organizations asking for changes in status and recognition. This development tends to reinforce the "service" value in hospitals rather than the "money" value.

But general problems for hospitals are also entailed by this drive toward professionalization. Each such group carries with it the beginnings of the charismatic behavior which we noted for the physicians. Each wants to become its own "boss" and is sensitive to the interference of (which may mean administration by) other groups. Again, the general authority of the hospital confronts groups of specialists, secure in the unique possession of their skills, who can say, and perhaps make it stick, "They've got to do

CHARGE MEDICAL GROUPS ENGAGED IN ILLEGAL CONSPIRACY

years. If that's illegal now, it has been illegal all the time."

At a press conference held at the time the petition was filed, hospital administrators, trustees and attorneys explained the lawsuit was not vindictive or punitive but was aimed simply at clarifying the legal rights of hospitals to bill for services as they have always done in the past. The state medical and radiology societies were not named as defendants, it was explained, because the purposes of the petition might become confused if so many groups were named, and "because hospitals feel demands made by a small group of pathologists do not represent the views of the great majority of doctors in Iowa."

Filing the petition on behalf of hospitals was Judge A. A. Herrick, special counsel for the Iowa Hospital Association. There are only 31 pathologists

(*Continued on Page* 184)

REPRESENT HOSPITAL ASSOCIATION AT CONFERENCE ON LAWSUIT

Fr. Kaufmann | Murphy | Herrick | Townsend | Byers | Jester | Blair | Cordes

it my way. Otherwise I'll quit—and just let them try to do it without me." Thus the nascent professions in hospitals may provide a set of motivations which aid the work of the hospital, at the same time that they complicate the organization needed for such work.

LABOR MARKET COMPETITION

Hospitals also, for many categories of workers, come off second best in the labor market competition. The higher pay scales and larger benefits in other kinds of enterprises remove hospital work from the consideration of many workers. These same advantages tend to draw many good people out of hospital work toward more lucrative jobs. In many hospitals this leads to what has been called "seniority by default"—the good people get out and entrenched mediocrity prevails. Also, the continuous nature of hospital work, which doesn't respect nights, week ends, holidays or family responsibilities, may be responsible for mobilizing a certain proportion of "queer people" into hospital work. This may in some respects be an asset—many of these "queer people" may devote their entire lives to the hospital, literally almost never leaving it. Their usefulness is attested by the remark of an administrator that if he only had enough "queer people" to handle the long hours and dirty work he could obtain an excellent office force. However, it is often the case with such isolated people that they present "personality problems" which are disruptive to hospital organization. This becomes crucial in those hospitals which represent a "closed community" of many people living-in 24 hours a day. Family-like interpersonal pathologies and mutually hostile cliques readily develop. Certain types of "queer people" can devastate such a situation. Since it does not operate purely according to the logic of profit a hospital may have greater tolerance for such deviants than does business, for example. But they represent a recurrent problem of hospital administration nevertheless.

The particular functions which a hospital performs for its medical staff also set the stage for administrative problems. It would take us too far afield to do more than sketch this out. Briefly, one can indicate that, for physicians, a hospital affiliation may include the following functions: provide prestige among colleagues, and within professional associations; condition the size and type of practice; permit the advancement of career by extending treatment facilities; provide a system of referrals and sponsorship, of mutual claims and obligations among fellow physicians, through which practices may be established or maintained, or specialties developed; may even provide office space for them in clinics where private patients are seen. The hospital, then, is an arena for medical professional development. Administration needs to understand how its hospital is involved in this since crucial matters such as size and type of case load and applications for staff and house-office positions may be importantly affected.

Recent research has stressed another dimension of hospital organization—its functions as a milieu of therapy. Studies, particularly in psychiatric hospitals, have shown that disturbances in the social field (social environment) of the patient, and these include interprofessional conflicts, are directly related to the course of patients' illnesses. Thus disturbances arise, and therapy may be hindered or implemented, because of factors in the hospital organization. The task of administration thus takes on hitherto unsuspected dimensions of therapeutic relevance.

This is probably particularly complicated in psychiatric hospitals. In these the task of the therapist often involves considerable individuation of patient treatment. Hospital administration, whose task includes that of establishing organizational patterns, is seen as the enemy of this therapeutic practice. Now, however, with our growing awareness of the relationship between a patient's milieu and his illness and recovery, there is good reason to believe that the establishment of proper organizational patterns by administration may very well conduce to patient health. Thus the dimensions of a new research problem emerge: the study of the relationships between the needs of individuation and organization in hospitals as these affect the health of the patients.

One of the things that emerges from the material presented is the clear need for further research to provide needed knowledge. This is true of the problem areas already addressed as well as of areas of hospital organization not yet explored.

In the latter category, for example, studies are needed of the community relationships of hospitals. What are the most effective means of community support and how may these be mobilized? What are the crucial relationships between different kinds of hospitals (*i.e.* by size, specialty and so on) and different forms of community (*i.e.* by size, region)? What are the real communities served by hospitals and how are these related to the localities in which they operate? Who are served from these communities, who not, and why? What are the community expectations of hospital service and functions, and how closely do these coincide with the survival contingencies of the particular hospital?

What about the recruitment of operating personnel? Do small-town hospitals need small-town people to operate them? Should they be local people or strangers, and for which kind of jobs? Do local people get caught in a web of kinship obligations that make it difficult for them to perform professionally? Can a stranger more easily be professional? Is he, however, so excluded from local community understandings as to be made less effective? Who, in a community, are best selected as trustees? These are part of a host of community problems involved in the administration of hospitals. Knowledge in these areas could greatly help administrators.

ADMINISTRATORS' FUNCTIONS

And, finally, study of the growing profession of hospital administration itself would be greatly rewarding. What are the observed functions of hospital administrators in different sizes and kinds of hospitals? How close are these to what administrators say they do and think they do? What are the intrinsic operating problems of hospital administrators? We have cited some of them—much more needs to be developed in this area. How close together are the expectations developed in professional training and the realities of this work? What is the image of this profession in the minds of other professions and of patients and the public? Is this a satisfying self-image for the hospital administrator, and if not, why? What and why are the relative advantages of being a physician or a layman in this job? The former feels guilty about not practicing medicine. The latter is denied intimate participation in many of the central interests of the institution. Is the professionalization of hospital administration tending to reduce this dilemma? Surely much new knowledge is needed here.

design postmortem at

Rockford Memorial Hospital

a detailed analysis of a superb new hospital in actual operation, conducted by those who know a hospital best— the men and women who work in it

This Hospital Looks as Good

EVERY day in every hospital, the architect's plan is given the hard test of actual operation — the building must perform the precise, complex functions for which it was designed. Usually, the results of the test stay bottled up in the minds of the doctors, nurses and others who do the work; except when major alterations are required, the planners are rarely called in and given the opportunity of seeing how well the plan has succeeded, and where it has failed.

Believing it would be an illuminating experience for all concerned if the architects for a hospital and the men and women who work in the hospital could be brought together face to face at the point where plan and function meet, The MODERN HOSPITAL chose for this novel "design postmortem" the beautiful new Rockford Memorial Hospital at Rockford, Ill. Opened a little less than a year ago, the hospital was acclaimed by experts for its efficient design. A committee of architects selected it as the "Modern Hospital of the Month" for September 1953, and another committee of architects and hospital authorities named it runner-up, or second choice, for "Modern Hospital of the Year." Visiting dignitaries from Europe and South America made the trip to Rockford to inspect its shining corridors.

All these, however, are simply the outward signs of success, and, like an expensive suit of clothes, they might conceal bodily defects. Only the men and women who work in it can know how good a hospital really is. So it was arranged that the architects (Perkins and Will of Chicago, in association with Hubbard and Hyland of Rockford) should come to the hospital for a series of meetings with John L. Brown, hospital director, and a group of medical staff members, department executives and employes. Everett W. Jones, vice president of the Modern Hospital Publishing Co., served as moderator for the discussions. Gordon Coster, photographer, went along and, as various hospital departments were visited and discussed, took the pictures shown on the following pages.

As the pictures and comments reported here plainly indicate, the criticisms that emerged in the discussions, for the most part, concerned minor details — a few more shelves here, a sliding door instead of a swinging door there, a cabinet that might better have been hung a few inches lower. This is not to say that the department heads were completely happy about everything else. Like department heads the world over, they wanted more space —for bigger offices, more conference rooms, additional secretaries and larger staffs. "If you gave every department head all the space he thought he needed," one of the architects remarked during the discussions, "your hospital would cover half the state!"

Postmortem conference at hospital includes (left to right): Administrator John Brown, Consultant Everett W. Jones, Architect Cliff Hyland, Housekeeper Odette Baldwin, Engineer Joseph Fox, Nursing Director Mrs. Glenn A. Erdmier and Architect Fred Kramer.

in Operation as It Did on Paper

With a single exception, however, the group agreed that the departments were well planned and carefully integrated and had successfully met the test of actual, day-to-day operation. Particularly, the critics admired the handling of the ground floor, where the architects achieved a smooth-running balance of space and traffic in administration, surgery, emergency and diagnostic areas, and the entire dietary department. "After a very careful study, I can say that the development and integration of all these departments on this ground floor are as successful as in any hospital I have ever seen," said Mr. Jones, a man who has seen his share of hospitals.

The one exception to the general satisfaction is the central sterile supply department. Conceived as a two-level operation with dumb-waiter communication from basement to ground floor areas, this department was disowned by architects and administrator alike, who attributed the concept to an earlier consultant to the old Rockford Hospital, but acknowledged that nobody in all the later planning conferences had understood how badly this department was laid out. Among other things, it was agreed that the central supply supervisor's office should have been provided on the ground floor level, where most of the work is done, instead of in the basement area, used largely for storage; there should be a separate area for glove washing and powdering; more storage space is needed in the working area; there is inadequate loading and unloading space at the large sterilizer, and the dumbwaiter for delivery of supplies to the nursing floors is badly located. Methods studies of the central supply operation are to be undertaken, Mr. Brown reported, as a necessary preliminary to rearrangement and reorganization of the department. Meanwhile, a set of plans for this department has been referred to a group of consultants in central sterile supply operation, whose suggestions for reorganizing the department will be published in The MODERN HOSPITAL next month.

One defect that was noted on the nursing floors, it turned out in the discussions, was caused by the kind of mid-course planning change that often occurs even in the best of building programs. As the nursing floors were originally planned, it was contemplated that bedpans would be flushed and washed in the toilets adjoining patients' rooms. After construction was well under way, however, a decision was made against installation of toilets with bedpan flusher attachments; as a result of this change, regular bedpan closets had to be added, taking space away from the linen closets and adding somewhat to the distance that has to be traveled by nurses. Another equipment change, from bedside cabinets with overbed swinging arms to

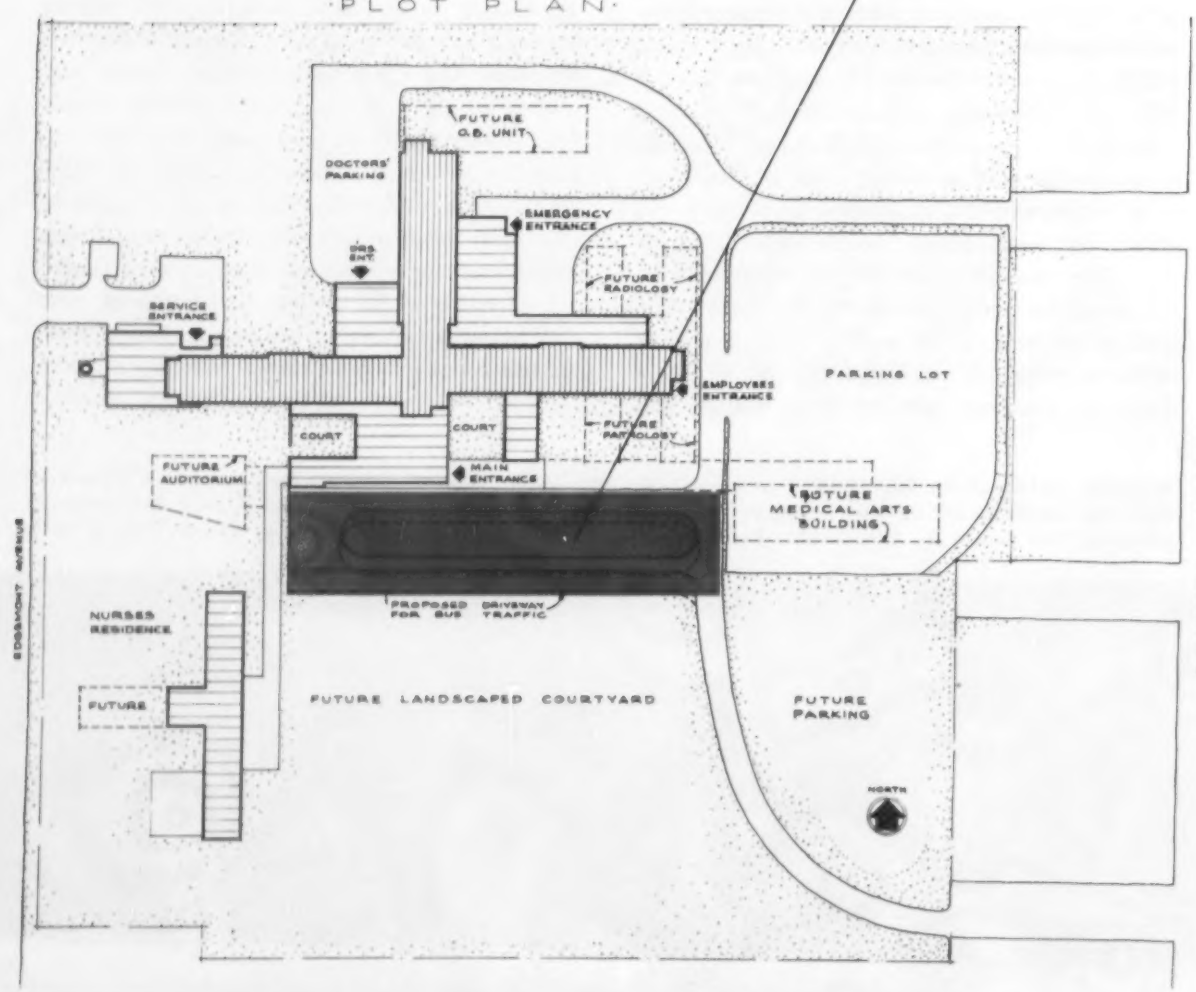
(*Continued on Page* 82)

At another conference, Architect Phil Will (at left on couch) answers a question raised by Jane Holt, chief admitting officer. Also in picture are Jones and Kramer, at left, and Assistant Administrator Paul Connor Jr., Administrative Resident George Caldwell, and Administrator Brown.

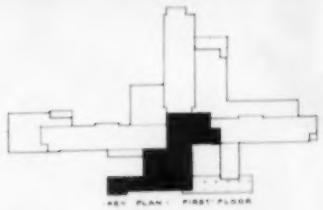
Parking

Plot plan shows separate entrances for public, doctors, emergency patients, employes and goods and services, with provision of generous parking areas for public and doctors. The main entrance (see picture at right) is served by a long, covered loading and unloading platform, where city buses stop. Experience has shown that driveway needs widening at this point (see diagram) to provide a few temporary parking spaces, always a convenience at main hospital entrance, and still permit bus traffic and turn-around without delays. This would require doorman.

PLOT PLAN



Administration

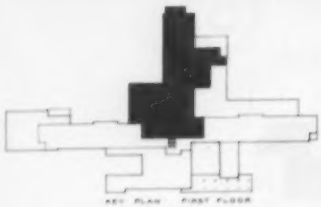


Attractiveness of the general lobby, gift shop and administrative area is indicated in picture below showing information counter at left, gift shop at right, and, at rear, entrance to elevators and outpatient area. Even the best laid plans may fall short of perfection, however, and here are a few details that have been adjusted as experience has indicated need:

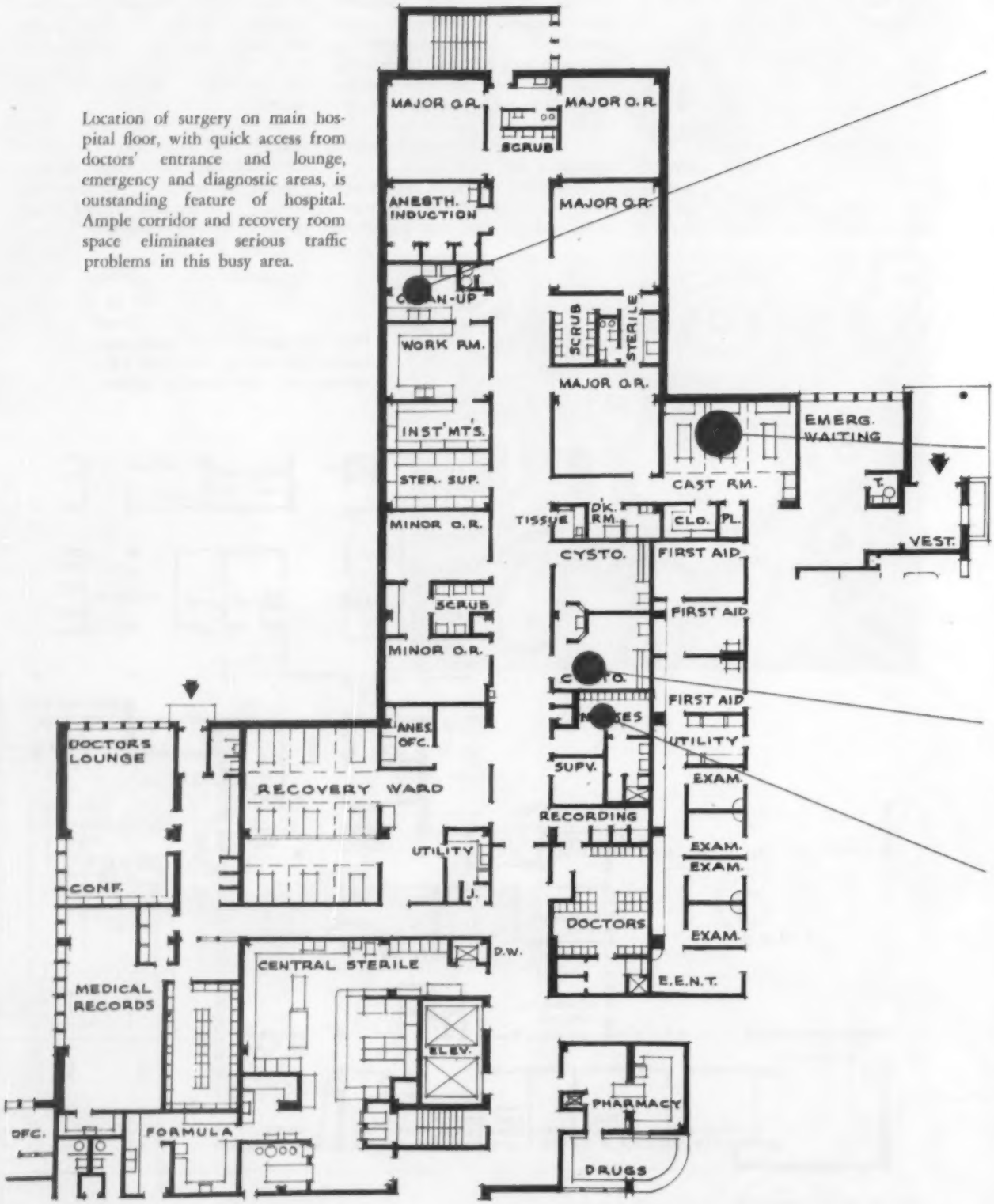
1. Easy access to general x-ray makes x-ray room in admitting department unnecessary; this space is used for volunteers to hang wraps in and, on occasion, as an extra admitting office, needed for peak periods in admissions.
2. Public relations and purchasing offices are actually used for assistant administrator and administrative resident, who were left out in planning. Secretary's office in administrative suite should be big enough for two secretaries, with enough room for chairs or "mourner's bench" for people waiting to see chief.
3. Small room (behind information counter) now used as credit manager's office was planned for accounting machines. Credit manager needs larger office for private interviews.
4. Door from information area into accounts receivable office (see photo and plan) wasn't there initially, had to be cut through when traffic problem developed after hospital was opened.
5. In addition, Admitting Officer Georgia Holt would like window in admitting office so she could see into general waiting area, and near-by space for storing one or two wheel chairs now kept at entrance.

Plan and picture show main entrance and waiting room with admitting and administrative offices.

Surgery

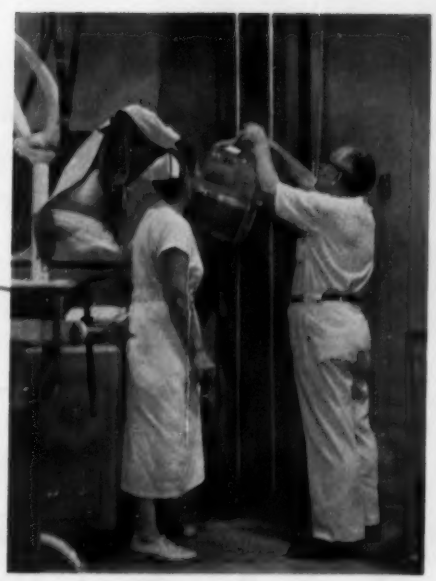


Location of surgery on main hospital floor, with quick access from doctors' entrance and lounge, emergency and diagnostic areas, is outstanding feature of hospital. Ample corridor and recovery room space eliminates serious traffic problems in this busy area.



Florence Conklin, operating room supervisor, wishes she had a separate storage room in the operating room suite, to avoid the kind of time consuming stoop-and-search that takes place now in clean-up room. More shelves would help, too.

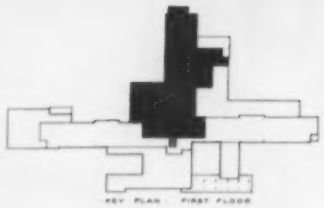
Cast room is spacious, located for convenient access to both emergency and surgical areas. Miss Conklin and Chief Orderly Walter Madison would like ceiling fixture with strap to hold patient's head when neck casts are applied.



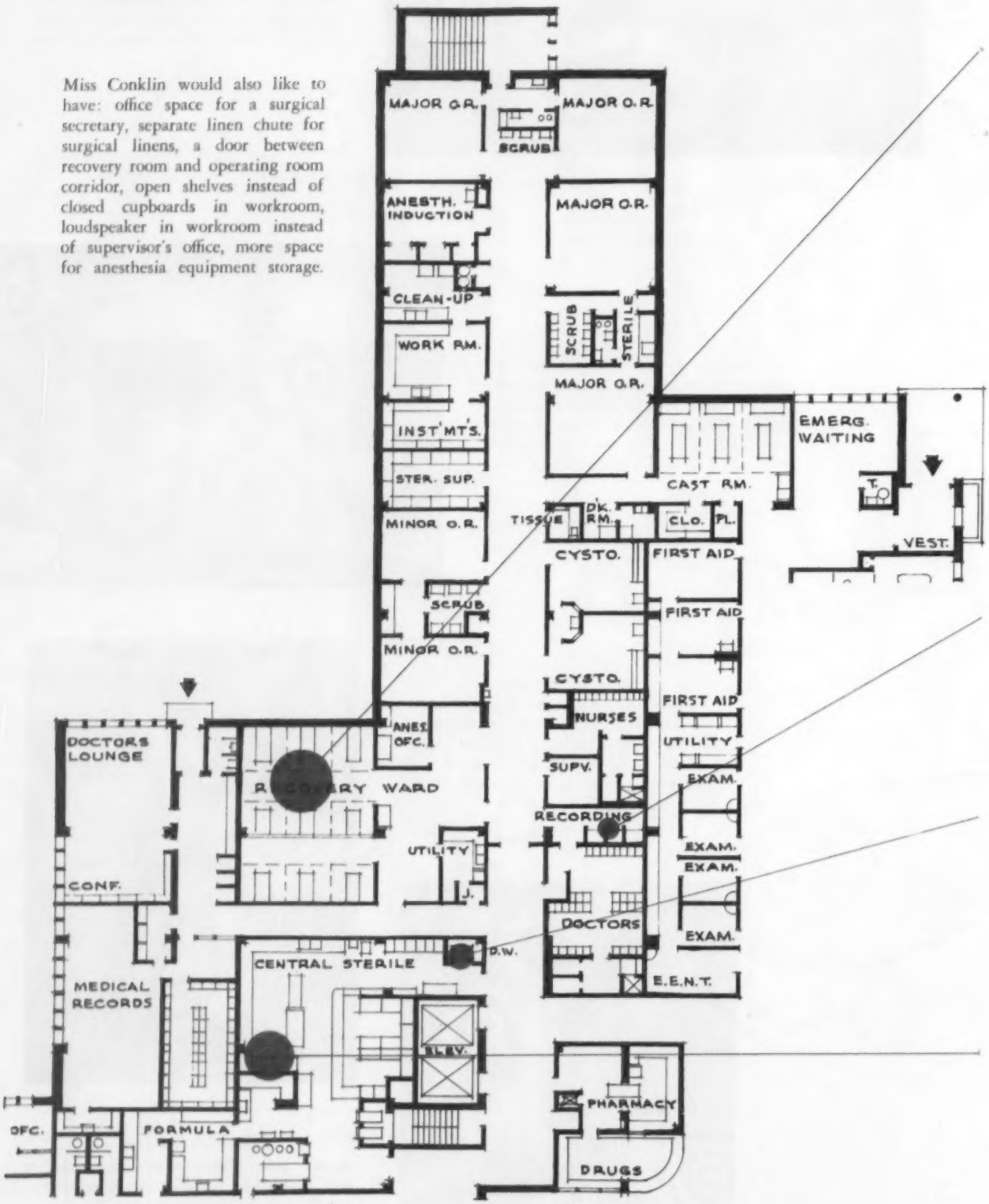
Walter Madison demonstrates simple hoist he designed to lift 5 gallon bottles of sterile water for use in cystoscopy room. Chief Surgeon E. G. Quattlebaum is delighted with physical layout and equipment of entire surgical area.

Nurses' locker room, intended for locker and wash room use only, has become a lounge and smoking room, and, as such, is badly overcrowded. This room could be twice its present size, it is estimated, and should be furnished as lounge.

Surgery (continued)



Miss Conklin would also like to have: office space for a surgical secretary, separate linen chute for surgical linens, a door between recovery room and operating room corridor, open shelves instead of closed cupboards in workroom, loudspeaker in workroom instead of supervisor's office, more space for anesthesia equipment storage.



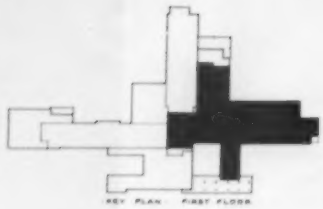
Nurse's desk outside recovery room provides efficient control point, but lack of doors here permits recovery room noises to be heard in corridor and near-by operating rooms.

Located just outside doctors' lounge, dictating booths can accommodate mobile file of unfinished records from medical record room down hall—a convenience that helps with records.

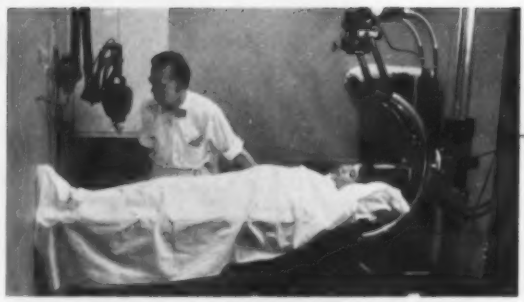
Planned for two-level operation (see basement plan on *p.* 82) central sterile supply room is seriously crowded, making efficient operation difficult. Worker at rear waits for dumb-waiter carrying supplies.

Another bottleneck is in sterilizing area of central supply room, where space is inadequate. (Suggested lay-outs to relieve congestion in central supply will be featured in The MODERN HOSPITAL next month.)

Diagnostic Services



Given generous space in ground floor wing, diagnostic services are used so actively that departments already wish for more room. For example, head radioscopic room is too narrow (right), requires adroit maneuvering to accommodate patients for examination. Room should be larger both ways.

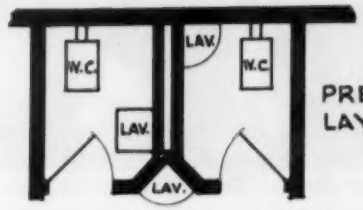


Associate Radiologist William Sneed insists on viewing wet films before patient leaves department, would like acidproof tile walls in this area, where paint and plaster walls get splashed. Dr. Sneed also needs more space here for wet film viewing, and wishes floor in area had drain.

Corridor bay for patients' stretcher carts is too small. Technicians would like room for three or four carts, a crib for child patients, and cassette tables. Dr. Sneed and associates dream of "back corridor" arrangement which would permit department traffic to move without using main corridor.

Dr. M. O. Alexander, pathologist, would be happier with more office space for secretaries and technicians. With space at premium, he regrets counters in lab were carried into corner (opposite page, below). This wastes undercounter storage space, which could be used for centrifuge.

AS IS LAYOUT

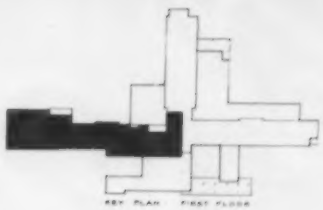


PREFERRED LAYOUT

BARIUM TOILET

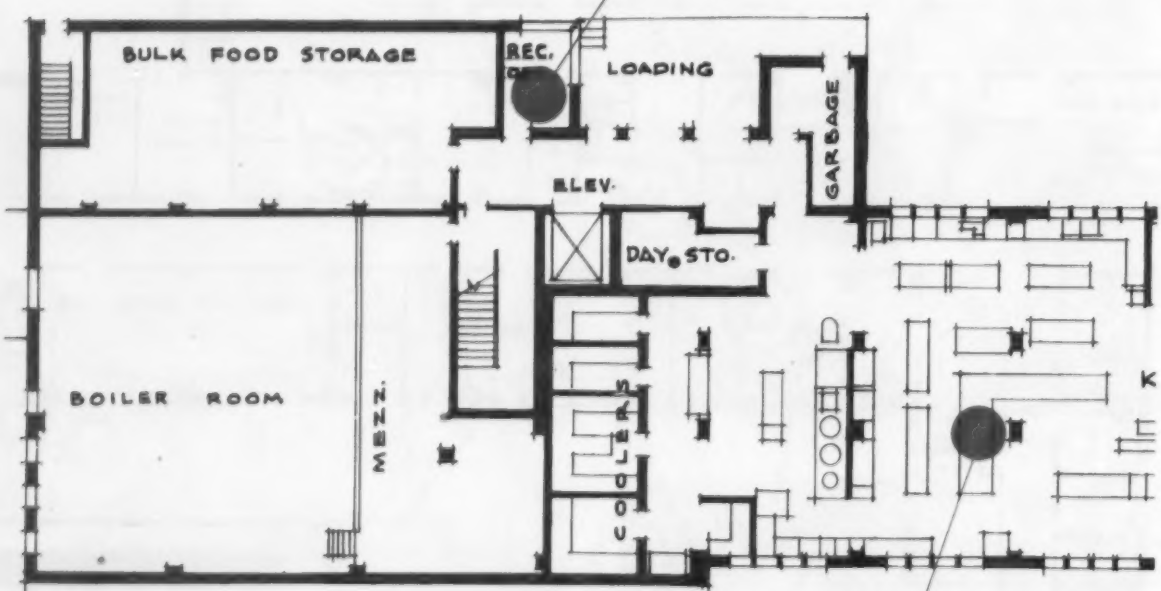
BARIUM ROOM

Kitchen-Cafeteria



Kitchen and food service areas were planned and equipped for operation of special, heated dish and tray cart system. According to Administrator Brown, "This type of service takes the urgency out of food handling. We can prepare meals well in advance of serving time so that production and work in the kitchen can be scheduled on an easy basis, and still serve hot meals." During study, consultant interviewed 30 patients on two different nursing units, at mealtime. Patients said they were getting hot food, praised food service.

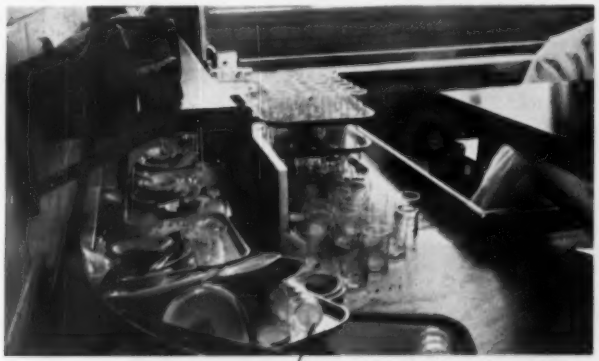
Food storage, receiving and loading areas are located for convenient access to kitchen. Picture at right shows clerk at multilith machine in receiving office. Loading platform may be seen through window at rear.



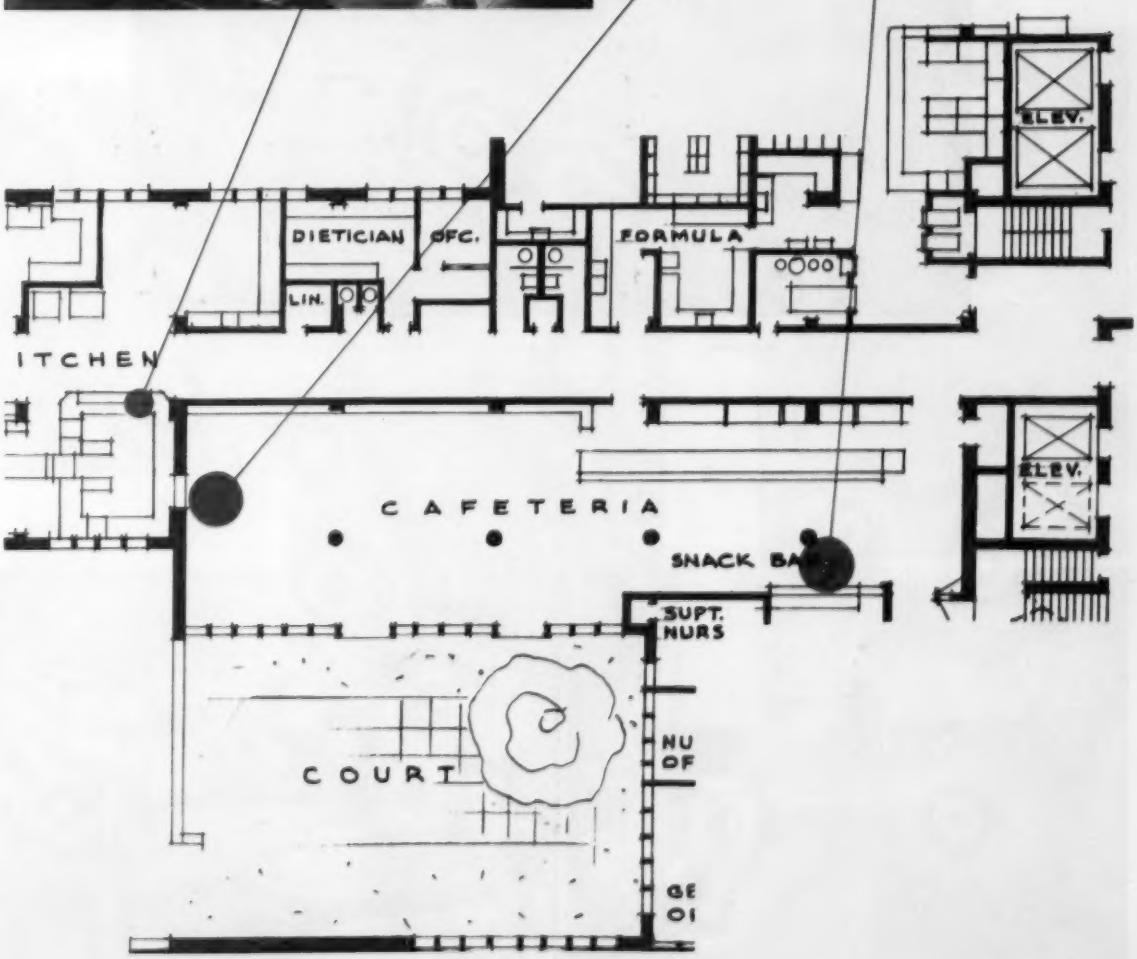
Here kitchen maids are working at efficient, well laid out tray assembly table. Dishes are placed on conveyor belt at right rear, and meal is assembled as dishes move down table toward maids in foreground, who add finishing touches to trays before loading on carts.

Cafeteria (right) serves all employes, visitors. Cafeteria looks out on pleasant court bounded on other sides by offices, corridor. Picture shows nurse at pass-through window to dish-washing area. For what happens on other side of this window, see picture below.

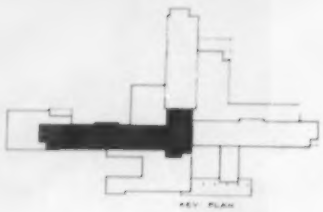
Picture below shows pile-up as dirty dishes are carried by conveyor belt into corner, where they must be removed promptly to avoid spilling onto floor with high breakage loss.



Popular snack bar could be larger.



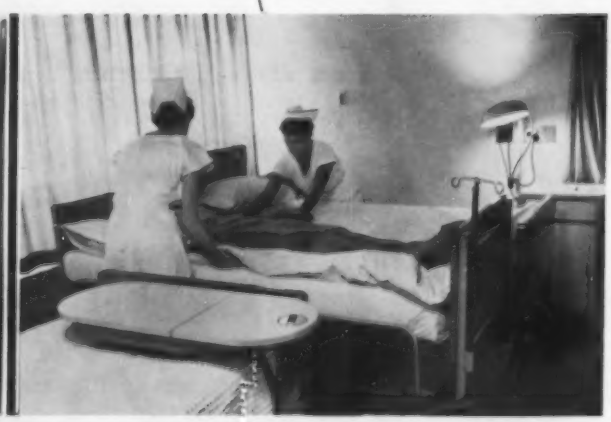
Nursing Unit

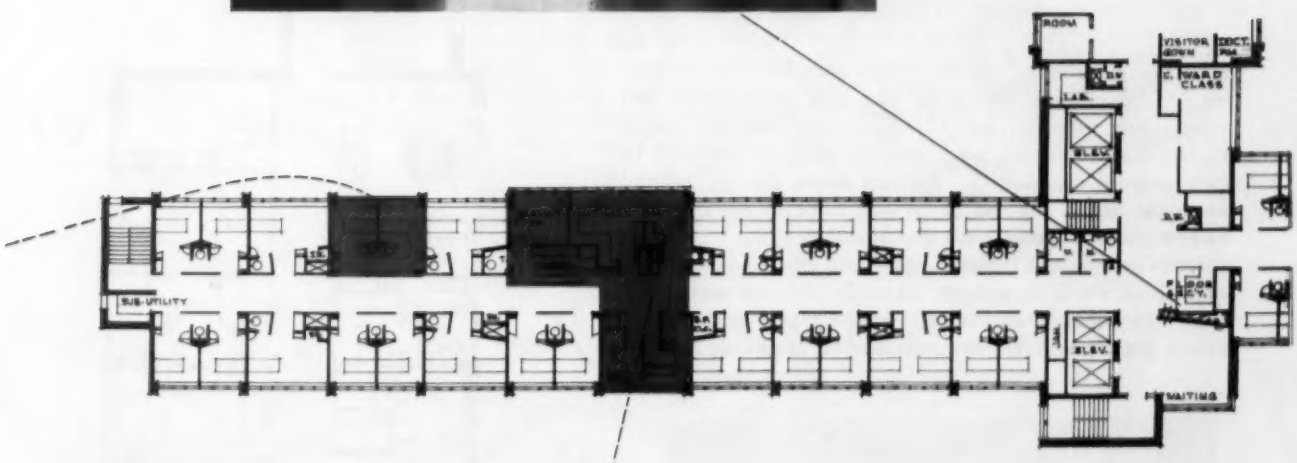


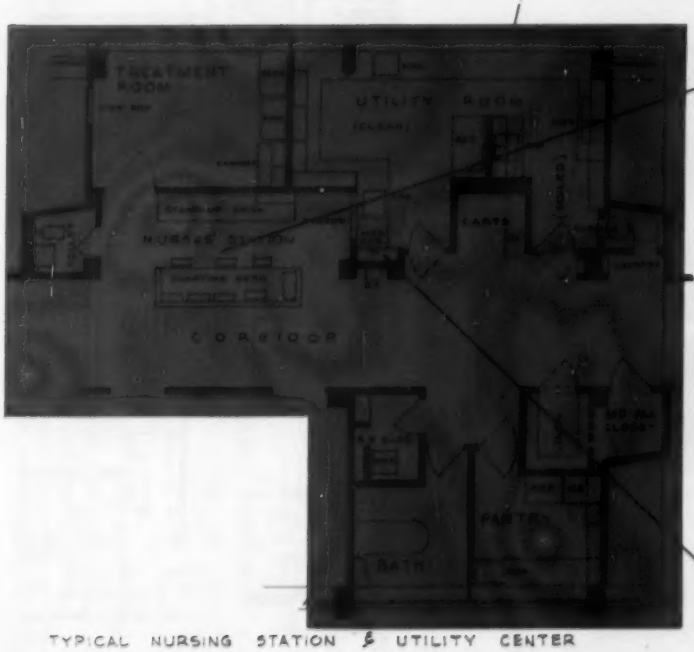
Nursing units were planned for patient interest and comfort, as well as nursing efficiency. Two-bed rooms are foot-to-foot style, giving both patients view through generous window area provided by continuous fenestration. In survey made by consultant, approximately 70 per cent of patients interviewed thought big windows were "wonderful!" Remaining 30 per cent took dim view of view, stating bright light and glare bothered their eyes, and if they pulled drapes to reduce glare they couldn't see anything at all. One patient complained of "draught," which proved to be cold air radiating from mullion between windows. Architect says proper adjustment of convectors and ventilators will eliminate this problem. Another problem occurs when patients must be transferred to stretcher bed for removal to surgery. Both single and double rooms are small, require maneuvering and moving furniture to effect transfer (see pictures). Corner lavatories (see plan) are problem when engineer replaces washers.

TYPICAL PRIVATE ROOM

TYPICAL SEMI-PRIVATE ROOM



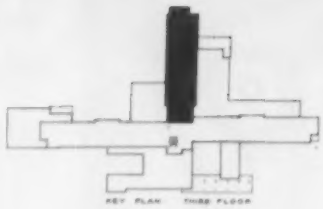




TYPICAL NURSING STATION & UTILITY CENTER

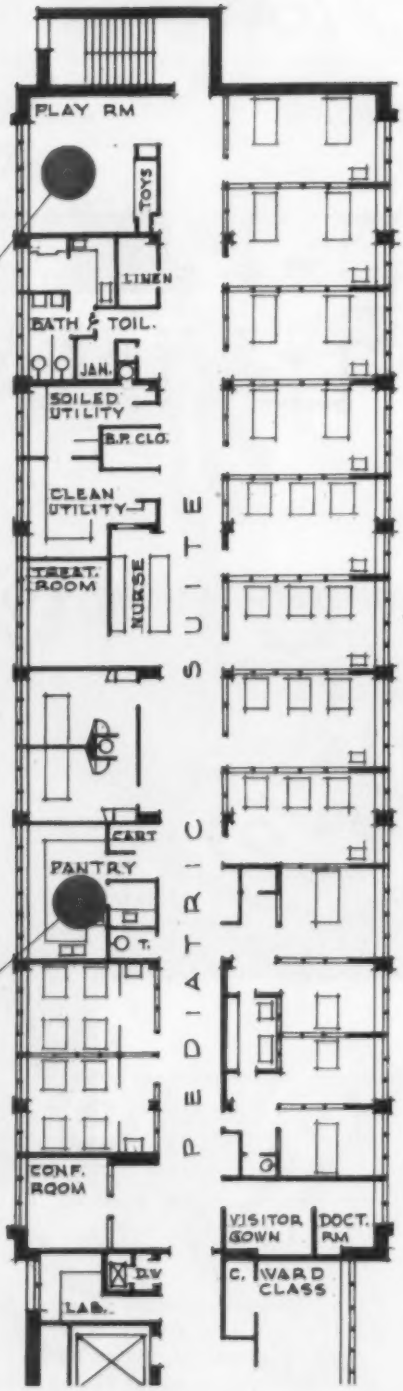
Entire nursing floor, with 32 patients, is served by floor secretary located in elevator lobby (see picture, top of page). Service area is nurses' paradise, according to Floor Supervisor Mrs. Byron Batchelder —except for short nurse, who must rise from chair to reach charts (upper right), stand on tiptoes to get medicines from cabinet, and chin self on pass-through window (lower right) which was originally planned to be for viewing only, changed later.

Pediatrics

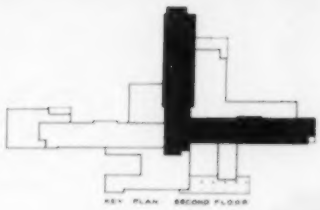


Pediatrics department, on third floor, includes cribs or beds for 34 children and has special play area for ambulant and wheel chair patients (see picture). Area also has special kitchen (lower picture) where patients' meals are prepared by cook assigned to this area. Pediatric meals are not included in central, heated dish and cart system, and cook has free hand to give children special treats and attention.

Interviewers found Pediatrics Supervisor Jean Lindaas enthusiastic about whole department, especially playroom and equipment. Department includes two rooms equipped with humidifiers to provide high humidity treatment for respiratory ailments.



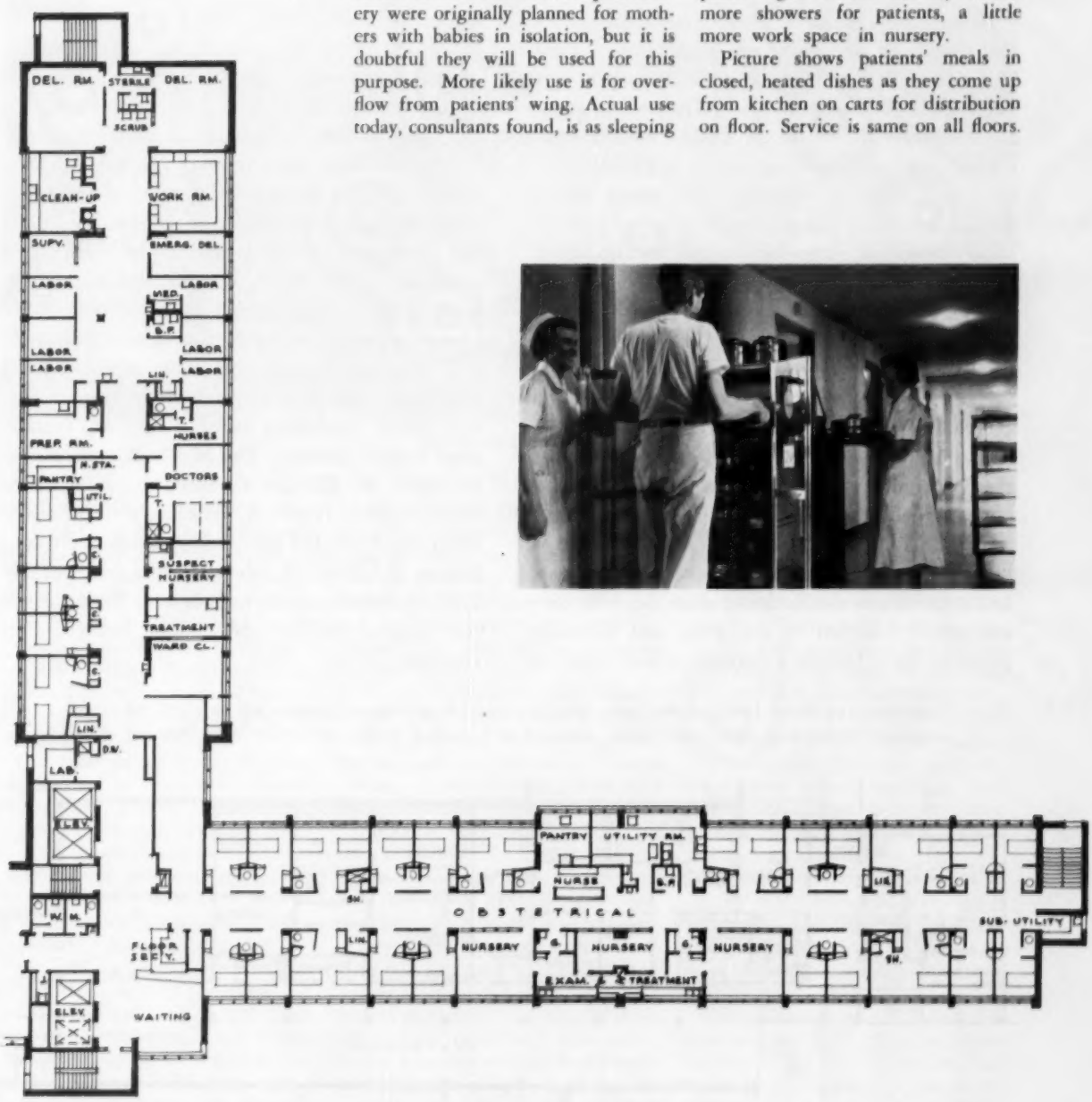
Obstetrics



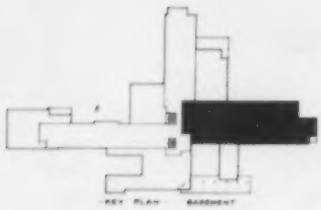
Obstetric department has 32 beds, with nursery facilities centralized in patients' area. Suspect nursery is around corner in delivery wing. Patients' rooms across from suspect nursery were originally planned for mothers with babies in isolation, but it is doubtful they will be used for this purpose. More likely use is for overflow from patients' wing. Actual use today, consultants found, is as sleeping quarters for obstetricians, residents and interns on call in obstetric department. Hospital today has total of 200 beds.

Obstetric supervisor would like telephone right outside delivery rooms, more showers for patients, a little more work space in nursery.

Picture shows patients' meals in closed, heated dishes as they come up from kitchen on carts for distribution on floor. Service is same on all floors.



Basement



(*Continued From Page 67*)

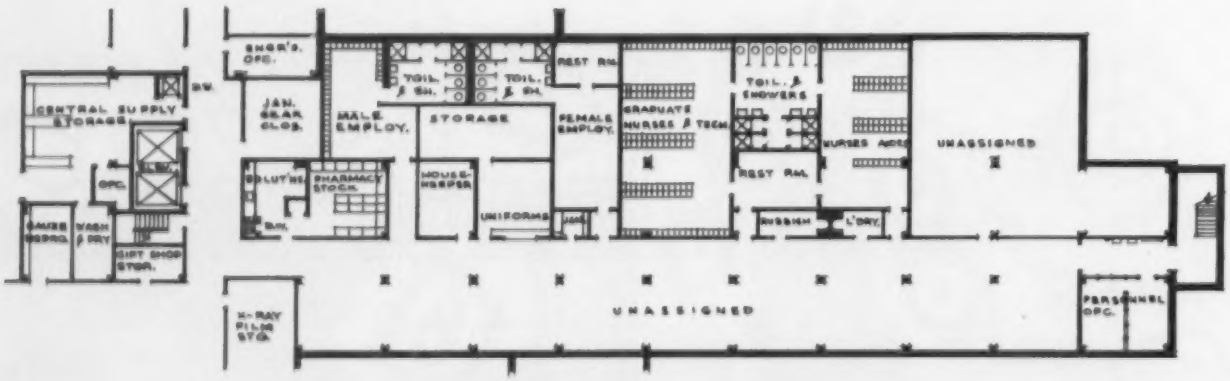
single pedestal overbed stands, added some congestion in patients' rooms.

Finally, the discussions brought out some points that cannot be seen anywhere in the plans. Thus Mrs. Odette Baldwin, executive housekeeper, was distressed about the quality of paint used in some areas, where walls cannot be washed without flaking off paint and early repainting is already indicated, and Engineer Joseph A. Fox would like 3 inch instead of 2 inch hot water lines, to prevent rapid cooling in extensions. Mr. Fox also voted against the corner washbowls installed in patients' rooms, which are so placed, he said, that only a left-handed acrobat can get at them to change packing washers in the faucets.

These and many of the details shown in the preceding pages would be done differently another time, the architects have acknowledged, adding that the opportunity to take part in a "design postmortem" of their hospital is an experience all architects should have. Actually, it is unlikely that many architects would come through such an experience as successfully as the Rockford team did, with only one major criticism of the plan, and abundant praise — by a hospital's severest critics — for its many outstanding feaures. All this, too, is in addition to the architectural beauty of the building, whose clean, horizontal lines reflect the precision and efficiency of the performance within.

In addition to Mr. Brown and the architects, hospital executives and employes taking part in the conferences included Georgia Holt, admitting officer; Mrs. Glenn A. Erdmier, director of nurses; Florence Conklin, operating room supervisor; Mrs. Amy E. Carlson, central sterile supply room supervisor; Mrs. Byron Batchelder, medical-surgical floor supervisor; Norma Breckenridge, obstetrics supervisor; Mrs. Alvin Bimm, assistant obstetrics supervisor; Jean Lindaas, pediatrics supervisor; Betty Larson, assistant pediatrics supervisor; Joseph A. Fox, engineer; George Plotner, laundry manager; Mrs. Odette Baldwin, executive housekeeper; Mildred Carse, purchasing agent; Ralph M. Terrant, chief x-ray technician; Dr. M. O. Alexander, pathologist; Dr. William R. Sneed Jr., associate radiologist; Mrs. Hibert A. Bowden, medical record librarian; Paul J. Connor Jr., associate director; George B. Caldwell, administrative resident; Dr. E. G. Quattlebaum, chief of surgery; Walter Madison, surgical orderly, and Eleanor Bennett, chief dietitian.

Basement area shown here includes lower level of central supply room (extreme left on plan), pharmacy, employes' locker and wash room areas. Laundry and autopsy rooms are under main hospital at left.



BASEMENT

THE MODERN HOSPITAL OF THE YEAR 1954

Architect's rendering of Long Island Jewish Hospital, Glen Oaks, N.Y.

THE Long Island Jewish Hospital at Glen Oaks, N.Y., has been named "Modern Hospital of the Year" for 1954 by a special committee of judges. The committee reviewed plans of hospitals published during 1954 in the "Modern Hospital of the Month" series and selected Long Island Jewish as "Hospital of the Year" on the basis of efficiency and economy in planning and construction.

The Long Island Jewish Hospital was designed by Louis Allen Abramson, architect of New York City. Dr. Eugene D. Rosenfeld, executive director of the hospital, was the consultant.

Members of the committee making the selection were W. H. Tusler of Minneapolis, a member of the Minneapolis firm of Magney, Tusler and Setter and chairman of the committee on hospitalization and public health of the American Institute of Architects; Frank S. Groner of Memphis, Tenn., administrator of the Baptist Memorial Hospital there and chairman of the American Hospital Association's council on planning and plant operation; Dr. Jack Masur, chief, Bureau of Medical Services, U.S. Public Health Service, Washington, D.C.; Marshall Shaffer, chief of the office of technical services, Division of Hospital Facilities, U.S. Public Health Service, Washington, D.C., and Everett W. Jones, vice president of the Modern Hospital Publishing Co.

As it finally emerged from a number of time-and-distance studies of nursing and other hospital functions, the basic plan for nursing units at Long Island Jewish is a double corridor with a 24 foot interior core; utilities and ancillary services within the core open on cross corridors rather than patient corridors. This design made it possible to keep the distance from the nursing station to the most remote patient's room to a maximum of 62 feet, with as many as 40 beds in a unit. "The Long Island Jewish Hospital has a compact, well studied plan, with exceptionally short nurses' travel, good food distribution, readily accessible services, and consideration given to noise, nuisance factors, and circulation," Mr. Tusler said, commenting on the design.

The hospital was opened in 1954 with an initial capacity of 214 beds and 40 bassinets; the plan provides for ultimate expansion to 500 beds; utilities, power plant, laundry, kitchen and other services are provided for 500 bed operation. Total cost of the project, including fixed equipment, was $5,770,000; cost of the completed hospital with 500 beds is estimated at $8,475,000.

A distinctive feature of the hospital is the complete, integrated intercommunications system, providing two-way communication between nurses' stations and patients' rooms, and between major departments. The communications system also includes an interior dial telephone circuit and a unique ultra-high frequency radio doctors' paging system. (For details of these communications installations, see page 134.)

Other hospitals receiving favorable mention from the judging committee included the Druid City Hospital, Tuscaloosa, Ala., designed by Charles H. McCauley, architect; and the Weld County General Hospital at Greeley, Colo., designed by Fisher and Fisher.

Recommended lighting practices

Put the Hospital in Its Best Light

NOYCE L. GRIFFIN
Electrical Engineer
Division of Hospital Facilities, Public Health Service, Washington, D.C.

LIGHTING for a hospital presents a number of problems peculiar to this type of building together with other normal lighting problems common to other types of construction. The specialized problems of lighting the operating and delivery tables are being successfully met. On the other hand, the patient's room with its varied lighting requirements is an area in which more research is needed to provide a completely satisfactory solution.

Proper application of the lighting materials presently produced by the various manufacturers will usually provide the lighting needed. However, research and improvements in lighting materials as well as in medical armamentarium continue to alter lighting concepts. In general, the demand for greater working efficiencies has resulted in a trend to higher lighting intensities.

This paper is intended to be helpful in designing lighting for hospitals by describing lighting requirements in the various areas and recommending the quality and quantity of lighting.

GENERAL

Lighting in all areas of the hospital should be designed for comfortable seeing. Fixtures should be durable, of a standard type, neat, of attractive design, easily cleaned and relamped. Wiring and switching should be arranged for convenient control.

Mat finishes for equipment, instruments, furniture and light colored draping materials for tables are desirable for minimizing glare where high intensities of lighting are required. The intelligent choice of interior finishes enhances the lighting effect and influences human emotions so as to produce either stimulating, neutral, restful or depressing reactions.

In areas such as offices, waiting rooms, maintenance shops, boiler rooms, kitchens, dining rooms, storage spaces, stairways and exits, the lighting may be treated approximately as in ordinary commercial buildings. In treatment, nursing and other specialized areas of the hospital the lighting should be designed for the particular specialty.

In some areas of the hospital, such as lobbies, large waiting rooms and work spaces, fluorescent lighting is usually preferred to incandescent lighting because it gives better lighting diffusion and requires less wattage per footcandle.

In patients' bedrooms or other areas where low intensities of lighting are desired, or where short burning hours are expected, filament lamp lighting is usually preferred to fluorescent lighting because of economy. Where color distinction is important, incandescent lamps (tungsten filament) are preferred. However, warm white de luxe fluorescent lamps have color characteristics reasonably close to that of filament lamps and may be quite satisfactory in most cases.

The installation cost of fluorescent lighting is generally more than that for incandescent lighting for a comparable class of fixtures, but where lighting intensities are more than 20 ft-c and lights operate long hours or continuously, the lower operating cost of fluorescent lighting usually makes it more economical in the long run. In addition to the lighting aspect, fluorescent lighting will achieve a saving in refrigeration of air cooled spaces as its heat output is only about one-half that of incandescent lighting for equal footcandles.

Fluorescent lamps are not suitable for use on circuits which are to be switched from A.C. to D.C. for emergency lighting.

The responsibility for the design of hospital lighting should be delegated to those with considerable knowledge of the functioning of a hospital as well as special training in lighting theory and its practical applications. The design engineer must also be familiar with the applicable codes, local ordinances, materials available, economy of construction, and maintenance problems.

GLARE AND DISCOMFORT

Discomfort from lighting is usually caused by direct glare from fixtures or reflected brightness from ceilings, walls, glossy paper, china, equipment and instruments. Some of the conditions affecting the degree of discomfort are the size of the light source or the number of unshielded fixtures in the field of view, the brightness of the lighting fixture, the location of fixtures with respect to the eye of the occupant, the angle of the line of sight from glare sources, such as reflected brighnesses from glossy surfaces of room and polished surfaces of equipment, the difference in brightness between lighting fixtures and their backgrounds, and the difference between the brightness to which eyes have been adapted and a higher brightness to which eyes are suddenly subjected.

Since the size of the light source is a factor which may contribute to lighting discomfort, fixtures in large areas or in long corridors should be shielded so that several fixtures do not appear

to blend into one large glaring light source.

For patients in private bedrooms, discomfort from lighting is usually caused by glare from fixtures in the center of the ceiling and from bright spots on ceilings or walls. For ward patients an additional source of discomfort is the direct glare from other patients' reading lights which are not of the proper type or need adjusting.

In operating and in delivery rooms, the high intensity of lighting needed may produce extremely annoying glare from metal instruments, equipment, white gowns and draping materials. Reflected glare from instruments and materials in the surgical field is one factor which affects the maximum practicable lighting intensity in operating rooms. The use of low gloss finishes for instruments, colored gowns and draping materials permits higher intensities of lighting without increasing the discomfort from reflected glare.

Discomfort is usually experienced when a surface brightness of the light source, or brightness produced by the light source, on the line of sight is about 250 footlamberts, or when about 500 footlamberts is less than 30 degrees above the line of sight. For comparison, a bare fluorescent lamp of the de luxe warm white, 40 watt T-12 lamp, has a brightness of about 1143 footlamberts. It follows that shielding would be required to provide for comfortable seeing with most lighting installations.

COMFORTABLE SEEING

For comfortable seeing of miscellaneous objects within a room, the difference in the brightness of lighting fixtures in the field of view and the surrounding areas, such as floor, ceiling and walls, should not be too great. Floors should be relatively light in color. Factors which affect comfortable seeing are *quantity*, or the level of illumination, and *quality*, which includes color of light, its direction, type of lighting system, diffusion and absence of glare. Suggested maximum brightness ratios of seeing task to surrounds of 3 to 1, 5 to 1, 10 to 1 and as great as 40 to 1 appear in the I. E. S. "Recommended Practices" for various conditions. For areas and surfaces immediately adjacent to the seeing task the brightness ratio should be of the lower order of not more than 3 to 1, while for slightly more remote surfaces, greater brightness ratios approaching 10 to 1 are satisfactory. For surfaces between lighting fixtures or surfaces adjacent to windows, brightness ratios up to 20 to 1 are considered good practice. For still more remote surfaces, as anywhere within the normal field of view, brightness ratios up to 40 to 1 are practicable.

CORRIDORS

A reasonable balance in the lighting of corridors with that of the adjacent spaces is desirable so that the contrast will be moderate when one enters one area from another. About 5 ft-c is sufficient for most corridors but may be raised to 10 ft-c or more in surgical suite, laboratory corridors, and in other corridors for special reasons.

Corridors in nursing areas warrant special treatment. Fixtures should be located so as to minimize the corridor light shining into patients' rooms. They should have enough capacity to provide about 10 ft-c for cleaning work, and be so wired that a number of the fixtures may be switched off for normal use. Wiring should provide for automatic connection of a few fixtures for emergency lighting. An arrangement somewhat similar to that shown in Fig. 1 is suggested.

WORK SPACES

Work spaces should be relatively free from sharp shadows and with sufficient illumination on work areas to eliminate the need for portable lighting units with the accompanying extension cords on floor or work areas. Supplemental lighting is desirable in many areas, such as over shop work benches and business machines where high intensities of lighting are needed. Steam laden areas, *i.e.* under kitchen hoods and above dishwasher, should have vaportight fixtures.

The general lighting should be fairly uniform so as to minimize spottiness and dark corners. Luminaire spacing in relation to ceiling height should be such that the minimum illumination at the work level between luminaires is at least two-thirds the maximum illumination under the luminaires.

CENTRAL STERILE SUPPLY ROOM

Highly reflecting materials, such as white fabrics, glass and polished instruments, constitute the greatest part of the materials handled in the central sterile supply room. To minimize reflected brightness from these materials and at the same time provide adequate lighting, only about 20 ft-c is recommended. Supplemental lighting should be provided where needed, such as for

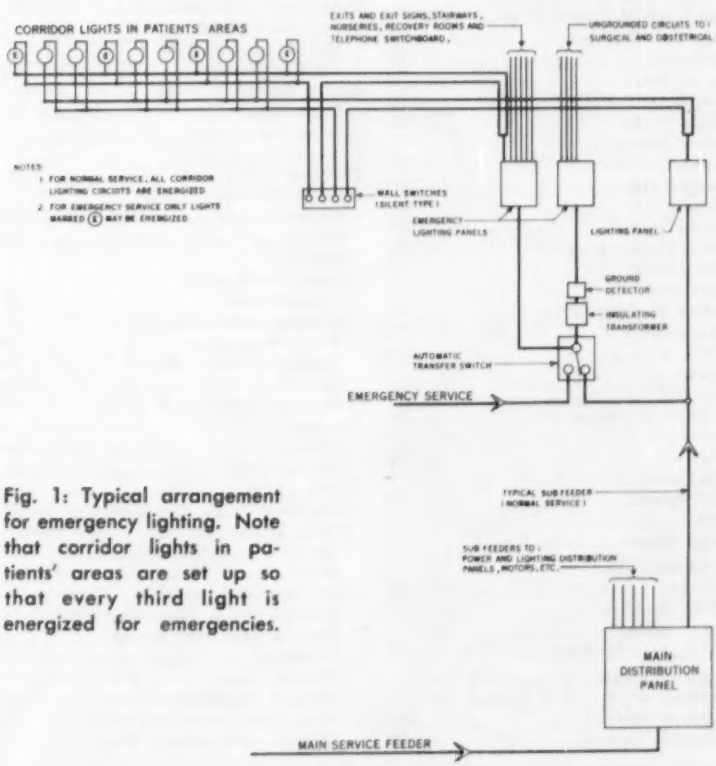


Fig. 1: Typical arrangement for emergency lighting. Note that corridor lights in patients' areas are set up so that every third light is energized for emergencies.

needle sharpening, where 100 ft-c or more is needed.

PATIENTS' ROOMS

Patients' rooms should have installed lighting for three distinct services: general illumination for the room, a reading light for each patient, and a night light. A fourth service, provision for a doctor's examination light, may be incorporated into the patient's reading light or it may be only a receptacle for a portable lamp with an extension cord. The general illumination should consist of a fairly low intensity of soft, well shielded light. While an intensity of about 10 ft-c is needed for room cleaning and during visiting hours, 5 ft-c is recommended for the normal nursing service.

The general illumination may be provided by a bracket light above the lavatory or bed, or by the table lamps, floor lamps, ceiling fixtures, or various combinations of the foregoing. Ceiling lights are not recommended for patients' bedrooms; direct glare from the fixtures or the reflected brightness on the ceiling is annoying to supine patients. Wall bracket lights may also produce some undesirable brightness on the walls, if not designed and located properly. However, they are preferred to ceiling fixtures.

Floor lamps and table lamps have been used for general illumination. They present, in a sense, more of a homelike appearance than do ceiling lights or wall bracket lights.

A variety of lighting fixtures has been used as patients' reading lamps with varying degrees of success. The type most frequently used are bracket lights of various forms, such as wall mounted or clamp-on-bed type units. Some are fixed units with no adjustments. Others have adjustable arms, louvers or brackets. Some include a night light and others have a detachable unit with hand grip for use as a doctor's examining light.

Floor lamps are also used as reading lights as well as for general illumination.

Fixtures with adjustable arms are generally satisfactory as reading lights but require considerable maintenance because of cord failure and because patients often damage them by pulling on the fixture arm in an effort to lift themselves in bed. In multi-bedrooms, improperly adjusted light may shine in other patients' eyes.

Reading lights should have sufficient beam spread to light the immediate

TABLE 1—HOSPITAL ILLUMINATION—NORMAL SERVICES

Space to Be Lighted	*Current Recommended Footcandles*
Anesthetizing & Prep. Room	20
Auditorium:	
Assembly	10
Exhibitions	30
Autopsy: (See Morgue & Autopsy)	
Boiler Room (See Power Plant)	
Central Sterile Supply:	
General	20
Needle sharpening	100
Corridor:	
General	5
Opr. & Del. Suites & Labs.	10
Cystoscopic Room:	
General	50
Cysto. table	200
Dental Suite:	
Waiting room	20
Operatory, general	40
Dental chair	400
Instrument cabinet	150
Laboratory, bench	50
Recovery room	5
Dining Room	10
Electroencephalographic Suite:	
Office	30
Workroom	20
Patients' room	5
Emergency Room:	
General	50
Local	200
EKG, BMR and Specimen Room:	
General	10
Specimen table, supplementary	30
Examination and Treatment Room:	
General	30
Examining table	50
Eye, Ear, Nose & Throat Suite:	
Eye exam. & treatment rm.	20
Ear, nose & throat rm.	20
Darkroom	10
Exits (at floor)	5
Flower Room	10
Formula Room	20
Fracture Room:	
General	50
Fracture table	200
Kitchen:	
Central	20
Floor, kitchen & pantry	20
Dishwashing	10
Laboratories:	
Office & assay rooms	30
Work tables	50
Close work	100
Laundry:	
General	20
Pressers & ironers	20
Sorting	30
Libraries	30
Linen Closet	5
Locker Rooms	10
Lobby	20
Lounge Rooms	10
Maintenance Shop:	
General	20
Work benches	30
Paint storage	5
Medical Records Room	30
Morgue & Autopsy:	
Autopsy room	30
Autopsy table	200
Morgue, general	20
Nurses' Station:	
General	20
Desk & charts	30
Medicine room counter	50
Nurses' Workroom	20
Nurseries:	
General	20
Examination table	50
Play room, pediatric	20
Obstetrical:	
Clean-up room	20
Scrub-up room	20
Labor room	20
Delivery room, general	50
Delivery table	200
Offices:	
General	30
Bookkeeping & fine work	50
Conference room	20
Information & switchboard	20
Retiring room	10
Parking Lot	5
Power Plant:	
Boiler room	5
Machine room	20
Switchboard room	30
Transformer room	10
Pharmacy:	
General	30
Work table	50
Active storage	20
Alcohol vault	10
Private Rooms & Wards:	
General	5
Reading	20
Psychiatric Disturbed Patients' Areas	10
Radioisotope Facilities:	
Radiochemical lab.	30
Up-take measuring room	20
Examination table	50
Sewing Room:	
General	20
Work area	50
Solariums	20
Stairways	10
Storage, Central:	
General areas	10
Office	30
Surgery:	
Instrument & sterile supply room	20
Clean-up room (instruments)	20
Scrub-up room	20
Operating room, general	50
Operating table	1800
Recovery room	20
Therapy:	
Physical	20
Occupational	30
Toilets	10
Utility Room	20
Waiting Room:	
General	10
Reading	20
X-Ray Room and Facilities:	
Radiography & fluoroscopy	10
Deep & superficial therapy	10
Darkroom	10
Waiting room	10
Office & viewing	30
Filing room, developed films	20
Storage, undeveloped films	10

surroundings rather than have a narrow beam for lighting only the reading page. Nonadjustable fixtures permit a neater and more uniform room appearance than the adjustable types do, but they are not as satisfactory for reading at the various elevated positions of the bed. Nonadjustable fixtures require careful placing to direct the light where intended and to protect other patients from objectionable light. They restrict rearrangement of furniture.

While night lights are sometimes installed in combination with the reading light, they are usually individual units of the flush type mounted 18 inches above the floor and located so as not to be covered by furniture or draperies.

For switching control of lights in patients' rooms, the usual practice is to switch the general illumination and the night light at the door. The patient's reading light is switched at the bed. Other switching arrangements may be more suitable where combination lighting units are used. However it is considered a "must" that some fixed lighting for the room, other than a plug-in unit subject to accidental detachment, be switched at the door for convenience of the nurse. Wall switches in patients' room should be of the silent type.

NURSES' STATION

Lighting at the nurses' station should be about 20 ft-c. The medicine preparation room, which is usually a part of or adjacent to the nurses' station, should have at least 50 ft-c for reading notations, treatment instructions, drug labels, measuring and instrument graduations. About 30 ft-c is needed for charting and other paper work.

UTILITY ROOM, NURSES' WORKROOM

High intensities of lighting may produce undesirable reflected brightness from utensils and other highly reflecting materials used or handled in utility rooms and nurses' workrooms. Only about 20 ft-c is recommended for those areas.

EXAMINATION, TREATMENT ROOMS

Examination and treatment rooms should have indirect or well diffused general lighting of about 30 ft-c. The examination and treatment table should have at least 50 ft-c.

OPERATING AND DELIVERY ROOMS

Operating and delivery rooms require general illumination for the room and special lighting for the table, each separately controlled. The special lighting for the table must supply all the light needed at the surgical or treatment area, without objectionable shadows from the surgeon's head, hands or instruments. It should be color corrected to near that of natural daylight, and without producing excessive heat on the surgeon or the patient. This lighting may be supplied by one or more units. Where only one unit is used, it should be supplied with two filament bulbs, or equally protected against total lamp failure.

Because of the difficulty of visually distinguishing different tissue, a rather high intensity of lighting is required on the surgical field for maximum seeing efficiency.

The current lighting recommendation for major surgery is a minimum of 1800 ft-c on the table at the center of a circular area 8 inches in diameter, and not less than 900 ft-c every place within that circle.

Most surgical lights have adjustable focusing mechanism so that the beam spread may be increased or decreased with a proportional change in lighting intensity at the table. Some surgical lighting units currently available will greatly exceed the minimum recommendations of 1800 ft-c. Some fixtures, fairly typical, will produce more than 4000 ft-c on the table when focused to an 8 inch beam, or about 10,000 ft-c when focused to a 4 inch beam. This is approaching maximum sunlight at the earth's surface and involves a corresponding heat problem.

While heat absorbing glass will absorb most of the infrared radiation additional means of heat control such as mechanical blowers may be employed where extremely high lighting intensities are required.

For comfortable seeing the general illumination for the room should be fairly high so that the difference in brightness of the surgical field and remote areas of the room will not appear too great. It follows that for a minimum of 1800 ft-c recommended for the table, an arbitrary minimum of 50 ft-c is recommended for general illumination so as to be within the brightness ratio of 40 to 1 recommended by the Illuminating Engineering Society.

At least one operating room should be provided with lightproof shades and fully equipped for darkening as may be required for fluoroscopy, for certain surgical cases, or for the use of lighted exploratory instruments.

In the lighting design for teaching hospitals, consideration should be given to installation of wiring for a television camera because such an installation may affect the type or installation of the surgical lighting fixture.

Delivery room lighting arrangement is similar to that for the operating room except that the lighting for the obstetrical table need not be so highly concentrated as for surgery. Usually 200 ft-c is ample for the obstetrical table.

CYSTOSCOPIC ROOM

The cystoscopic room should be lighted similarly to delivery rooms. Provision should be made for darkening the room for use of lighted exploratory instruments and for fluoroscopy.

FRACTURE ROOM

Fracture rooms require about the same scheme of lighting as operating

(*Continued on Page* 144)

TABLE 2—HOSPITAL ILLUMINATION—EMERGENCY ONLY

Space to Be Lighted	*Minimum Recommended Footcandles*
Operating room	Surgical light
Emergency room	Surgical light
Delivery room	Obstetrical light
Exits	1.0 at floor
Exit—direction signs	5.0 on illuminated face
Stairways	1.0 on stair tread
Corridors	1.0 at floor
Nurseries:	
Newborn	10.0 30" above floor
Premature	10.0 30" above floor
Pediatric	2.0 30" above floor
Recovery room, surgical	10.0 30" above floor
Telephone switchboard	5.0 on face of board
Boiler or machinery room	5.0 at selected location

ABOUT PEOPLE

Administrators


Richard M. Loughery

Richard M. Loughery, former assistant administrator of Garfield Memorial Hospital, Washington, D.C., has been appointed administrator there, succeeding **Leo G. Schmelzer,** who is now administrator of Wilmington General Hospital, Wilmington, Del. Before joining Garfield in 1953, Mr. Loughery was personnel director, then senior administrative assistant at Methodist Hospital, Indianapolis. He is a member of the American College of Hospital Administrators, American Hospital Association and Maryland-District of Columbia-Delaware Hospital Association.

Fred C. Roeseler, assistant administrator of Milwaukee County Asylum, Milwaukee, has been appointed superintendent of Milwaukee County Infirmary, Milwaukee, to succeed **Fred J. Oeflein,** who will retire November 1. Mr. Roeseler will begin his service at the infirmary two months prior to Mr. Oeflein's retirement. In the meantime, Mr. Roeseler will remain at the asylum to assist the newly appointed medical director, **Dr. Ernst Schmidhofer.** Dr. Schmidhofer has been chief of neuropsychiatric service at Veterans Administration Hospital, Jackson, Miss.; as medical director of Milwaukee County Asylum, he succeeds the late **Dr. Ralph M. Fellows.** Mr. Roeseler is a member of the American Society for Public Administration, the Wisconsin Hospital Association, and the Milwaukee County Society for Mental Health.


P. Arthur Capitanelli

P. Arthur Capitanelli, who has been assistant director of the methods improvement program at St. Luke's Hospital, Chicago, has been named assistant director of Presbyterian Hospital, Chicago. Mr. Capitanelli will be in charge of coordinating the hospital's clinic services. From 1946 to 1954 he was registrar of the Veterans Administration Hospital, Sunmount, N.Y.

Frank L. Porter, formerly administrator of General Hospital of Saranac Lake, Saranac Lake, N.Y., is now assistant administrator of Jefferson-Hillman Hospital, Birmingham, Ala. Also named assistant administrator at Jefferson-Hillman is **James E. Crank,** for-


Frank L. Porter


James E. Crank

merly assistant to the director of local health organizations, Georgia Department of Public Health. Mr. Crank received his M.P.H. degree in health administration from the University of North Carolina. A graduate in hospital administration from Columbia University, Mr. Porter served as assistant administrator of Episcopal Hospital, Philadelphia, where he also served his administrative residency. Mr. Porter is a nominee of the American College of Hospital Administrators.

Harry Smith, former administrator of Wesley Hospital, Oklahoma City, Okla., has been named administrator of Southern Oklahoma Memorial Hospital, Ardmore, Okla. Tentative opening date of the new hospital is March 15.


Donald L. Ford

Donald L. Ford, who has been a research assistant for the Hospital Council of Philadelphia, has been appointed administrative assistant of Children's Hospital of Philadelphia. A graduate of DePaul University, Chicago, Mr. Ford attended Northwestern University and the universities of Louisville and Indiana for graduate study.

John Jenkins, superintendent of Beyer Memorial Hospital, Ypsilanti, Mich., for the last seven years, has resigned. He plans to take up a new administrative position in an Illinois hospital. Formerly Mr. Jenkins was assistant in the business office of University Hospital, Ann Arbor, Mich.


Joseph Karlton Owen

Joseph Karlton Owen, who has recently received a degree of doctor of philosophy in hospital administration from the State University of Iowa, returns to his former position of assistant director of the hospital division at the Medical College of Virginia, Richmond. Mr. Owen is the fourth person in the nation to receive a Ph.D. degree in hospital administration. He received his M.H.A. from Columbia University.

Ann Bland, administrative assistant of Mound Park Hospital, St. Petersburg, Fla., has become administrative consultant with the hospital planning division, Division of Hospital Facilities, Florida Improvement Commission. Miss Bland received a graduate degree in hospital administration from Northwestern University.

Sister Hermine, who has been administrative assistant of St. Mary's Hospital, Milwaukee, for the last two years, has been appointed administrator there. She succeeds **Sister Rose,** administrator for the last 12 years.

Alice DeCanio has been named administrator of the new Memorial Hospital, Claremore, Okla.

T. A. Carroll, formerly a member of the board of managers of Memorial Hospital, Palestine, Tex., is now administrator there, succeeding **Ruth Mallory,** who has resigned.


Robert L. Denholm

Robert L. Denholm, who has been acting director of hospitals at the University of Colorado Medical Center, Denver, for the last year, has been appointed director of hospitals with supervision over both Colorado General and Colorado Psychopathic hospitals at the university. Mr. Denholm is a graduate in hospital administration from Northwestern University.

(*Continued on Page 206*)

Synchronized Purchasing Is an Art

This system achieves the purchasing agent's goal: To have the right material at the right place at the right time at the right price

ALFRED E. SCHLEF
Purchasing Agent
Bethesda Hospital, Cincinnati

SYNCHRONIZED purchasing was developed and put into effect at Bethesda Hospital, Cincinnati, during the last two years as part of an overall economy program. We were faced with limited storeroom space as a result of the modernization of our kitchen and new cafeteria. On investigation, it was also found that we had accumulated various items that were no longer being used. How to utilize our storeroom space and present inventory dollar to the best advantage was part of the problem at hand. To this end the purchasing department endeavored to eliminate all unnecessary items and still keep a reasonable amount of essential stock.

Synchronized purchasing is a technic of timing, flow control, and distribution. The art of purchasing involves having the right material at the right place at the right time at the right price.

Synchronized purchasing is akin to an internal combustion engine. In an internal combustion engine it is necessary to have the proper air-gasoline mixture at the right compression with the proper spark. In order to receive maximum efficiency from the engine, various parts must be synchronized so that the whole engine runs in a coordinated manner. So, also, must the purchasing department be synchronized to the relationships in the whole function of any organization.

The following functions are necessary for synchronized purchasing: (1) standardization of stock, (2) master control, (3) measured issue, (4) correlated purchases. The development of each of these functions is discussed in relationship to the whole operation of the organization and in relationship to one another.

The standardization program was approached with the full cooperation of the administrator, the various department heads, and appropriate members of the medical staff. From primary studies by the administrator and purchasing agent it was found that the nursing department would be most affected.

COMMITTEE STUDIED PROBLEM

The director of nurses was asked to form a committee representing the various departments that would be involved. The following were appointed as members of the committee: the director of nurses, central supply supervisor, operating room supervisor, maternity supervisor, nursing education representative, and nursing instructor. The purchasing agent was the administration's representative to the committee. The function of the committee was to find the smallest number of items that would give the most efficient service for each type of function performed. Great care was taken to ensure that there would be no sacrificing of patient service. Whenever supplies and equipment are standardized, in the process certain technics and procedures also become standardized. Therefore, we studied not only the material itself but also its effects on labor and patient care.

Sufficient notice was given to all departments concerned before any change became effective in order to minimize or eliminate any confusion that might result from too hasty a change. By its very nature the committee took on the functions of: (1) instructing employes in the proper use of new products; (2) acquainting personnel with the value of supplies and equipment; (3) enlisting the cooperation of the employes and promoting their suggestions.

Each stock item was reviewed with representatives of the various departments that either used or in some way handled that item in order that their experience could be used in helping and guiding the committee. The laundry manager and executive housekeeper were of great assistance in the standardization of textiles. The laundry manager attended the meetings on textiles and he was able to demonstrate to the committee how the use of certain uniforms and gowns could save pressing time in his department.

Usage records were presented by the purchasing department. These records show a breakdown of related items in use by various departments and the quantities used by each department within a specified period of time. Thus the committee was able to see how much was being used each month not only by the hospital, but also by

each department. From these records the committee was able to select items which overlapped in use and to standardize on the one they believed would give the most efficient service. Thus more storage space was made available for items in constant use. The best methods with the most suitable equipment were then put into use. The total inventory was reduced approximately 30 per cent in the number of items carried, *i.e.* 22 sizes of hypodermic needles were reduced to six sizes; 16 sizes of sterile wrappers to three.

COMMITTEE IS NOW PERMANENT

The committee activity was considered of such importance that it is now permanent. The functions are still being continued and at present the committee is working on re-reviewing paper supplies in order that further standardization may be accomplished. The committee is on a constant lookout for new products and methods that may improve patient care. A careful check is maintained in order that products can be dropped from stock as they become obsolete.

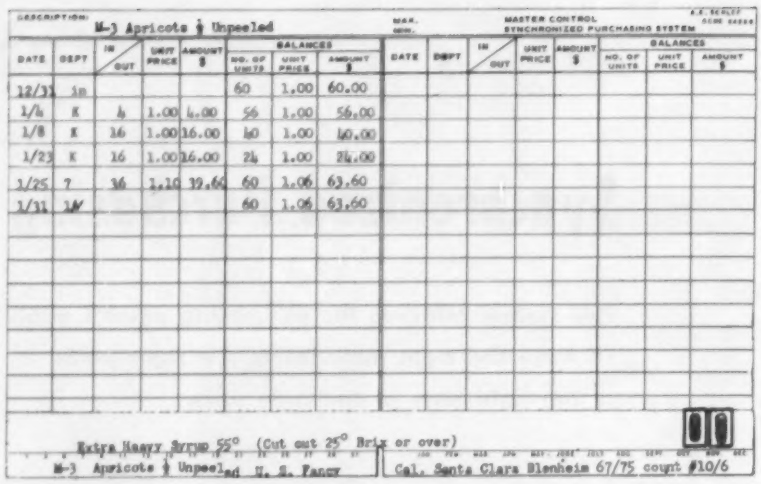
The next problem was the development of a master control. The master control differs from a perpetual inventory in that it must contain information in addition to that required for an accounting perpetual inventory. A detailed description of the master control and the way it operates is shown on these two pages.

The stock books that are used by each department are a vital part of our master control because they add to the accuracy of the perpetual inventory section and the tabulated usage records.

All stock items are listed in the stock book under such categories as Utensils, Sutures, Stationery, Office Supplies, and so on. They are further listed alphabetically. Every stock item has a stock number.

In order to obtain material, the person who is placing the order (1) looks up the desired item on the alphabetized list or the categorized listing; (2) enters on the prescribed storeroom requisition form (PF 166C) the quantity desired, the stock number, and the description as it appears in the stock book, and (3) submits the requisition to the storeroom where it is filled.

Example: If an invalid ring is wanted it is looked up under "rubber goods" in the categorized section. An invalid ring is Item E-30. Therefore, it is entered on the form under Quan-



DESCRIPTION: M-3 Apricots ½ Unpeeled — MAX. — MIN. — MASTER CONTROL SYNCHRONIZED PURCHASING SYSTEM — A.S. SERIES

DATE	DEPT	IN / OUT	UNIT PRICE	AMOUNT $	BALANCES NO. OF UNITS	BALANCES UNIT PRICE	BALANCES AMOUNT $	DATE	DEPT	IN / OUT	UNIT PRICE	AMOUNT $	BALANCES NO. OF UNITS	BALANCES UNIT PRICE	BALANCES AMOUNT $
12/31	in				60	1.00	60.00								
1/4	K	4	1.00	4.00	56	1.00	56.00								
1/8	K	16	1.00	16.00	40	1.00	40.00								
1/23	K	16	1.00	16.00	24	1.00	24.00								
1/25	7	36	1.10	39.60	60	1.06	63.60								
1/31	LW				60	1.06	63.60								

Extra Heavy Syrup 55° (Cut out 25° Brix or over)

M-3 Apricots ½ Unpeeled U. S. Fancy — Cal. Santa Clara Blenheim 67/75 count #10/6

Above: Master Control Summary Card. Color indicators are used as follows: Blue means an item is approaching the ordering point. Shading indicates item on order. Both indicators are used to show that shipment of an item is overdue. Entries on card shown in blue here are red entries in actual practice, indicating withdrawals.

HOW THE MASTER CONTROL SYSTEM WORKS

DESCRIPTION:

The description shows what the article is. On our example, the stock number is M-3 and the material is Apricots ½ Unpeeled U.S. Fancy California Santa Clara Blenheim 67/75 count #10/6 in Extra Heavy Sirup 55° (cut out 25° Brix or over). It further indicates that this material is kept in section M in the subbasement storeroom shelf #3.

DATE:

The date is the actual date that any materials are received or issued. It also indicates the closing date. The closing date is the last day of the month. At this time a paper inventory is shown. Once a year a physical inventory is taken on all items. A physical check is made on two to three sections each month against the paper closing inventory in order that the accuracy of inventories can be checked to disclose any source of error, and that appropriate means may be taken to correct them.

DEPARTMENT:

This column indicates to what department the items were issued and from what suppliers materials are received.

IN/OUT:

Indicates quantity received or issued.

UNIT PRICE:

This indicates, on shipments received, the actual unit price; and on items issued, the average unit price (see also balance unit price).

AMOUNT:

Amount is the total dollar value of the transaction.

BALANCES:

Balance Number of Units

This indicates the actual number of units on hand in the storeroom.

Balance Unit Price

This is the average unit price of the items in stock. It is derived by taking the total dollar value of the number of units on hand and dividing the total dollar value by the number of units. If a shipment comes in at a different price the old and new balances are added together and the old and the new number of units are added and then divided.

Balance Amount

This is the total dollar value of the actual stock of each item on hand.

DESCRIPTION:
MEASURED ISSUE: M-3 Apricots ½ Unpeeled

MASTER CONTROL SUMMARY
SYNCHRONIZED PURCHASING SYSTEM

VENDORS	1	Flach	5	Blome
	2	Baggett	6	Thomas
	3	Niehaus	7	White Villa
	4	Cincinnati Foods	8	

RECAP

YEAR	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL	MONTHLY AVERAGE
1954	36													

ORDER RECORD				RECEIVED				UNIT COST	ORDER RECORD				RECEIVED				UNIT COST
DATE	VEN.	ORD. NO.	QUANT.	DATE	QUANT.	TRANS.	TERMS		DATE	VEN.	ORD. NO.	QUANT.	DATE	QUANT.	TRANS.	TERMS	
1/23	7	00001	36	1/25	36		net	1 10									

Above: Perpetual Inventory Card. The information shown on the opposite page, *i.e.* description, date, department, in/out, unit price, amount and balances, is recorded on this card. The explanation of a hypothetical example given here shows how these data are coordinated into a smoothly working operation.

EXPLANATION OF HYPOTHETICAL EXAMPLE

On Dec. 31, 1953, an actual inventory was taken whereby it was found that *60* cans of item *M-3* Apricots ½ Unpeeled were on hand at a unit price of $1, thus giving a total amount of $60. On January 4, the kitchen requisitioned four cans of M-3 Apricots ½ Unpeeled so under Department "K" was entered to show kitchen; under column In/Out, 4 was entered to show 4 cans; under Unit Price, $1 was entered to show the cans cost $1 each, thus $4 was shown under "Amount." This leaves a balance of 56 cans in stock which is indicated under "Balance Number of Units." The price remains the same at $1 per unit, thus $1 is placed under Unit Price and the total dollar value of the remaining 56 cans is indicated under "Amount" at $56. This and the following two entries are shown in color in sample on opposite page.

On January 8, 16 cans were used by the kitchen, thus under In/Out 16 is indicated at a unit price of $1 each, giving the total amount of $16. Under balances we have a remainder of 40 units (56 less 16) 40 x $1 (balance unit price), giving a balance of $40.

On January 23, the kitchen again requisitioned 16 cans and the same process is carried out, leaving a balance of 24 cans at $1 each, giving a total dollar value of $24.

Also on January 23, Purchase Order No. "00001" was issued to the White Villa Corporation; therefore the date 1/23 was posted in the Date column of the Order Record section of the master control card and under Vendor "7" was posted indicating the White Villa Corporation, which is shown as Vendor "7" under section marked Vendors. The quantity ordered was 36 cans (6cs.). Still on the master control card under Received the following postings were made on January 25 showing the amount received. First the date is posted, then quantity. The terms were posted on the 23d from the Purchase Order and also unit cost; this time the price was $1.10.

On the same date on the perpetual inventory card under Department, Vendor #7 is indicated. Under column In/Out 36 is indicated and Unit Price of $1.10 is posted. Under Amount, $39.60 is posted showing the total dollar value of shipment received. Under Balances, *60* is now posted (36 received plus the 24 which were on hand). The next column to be posted is the amount. This is the total of the dollar value of the amount received, *i.e.* $39.60, and $24 which is the dollar balance of the amount on hand, giving a total of $63.60 and a new unit price of $1.06.

On January 31, the closing date of the inventory, the previous balances are reentered and checked for mathematical error. Thus, the entry on 1/31 reads as follows under Date, under Department "In," under Balances, Number of Units 60, Unit Price $1.06, Amount $63.60. At the same time all of the Out figures are totaled in this particular example: 4-16-16 for a total of 36. This is entered under "recap" 1954 January as 36. At Bethesda Hospital the definite time period of one month is used as a final tabulation unit for each item. Some hospitals may find it more convenient to use a cycle of 28 days.

tity — *1*, Stock Number — *E-30*, Description—*Invalid Ring*. Similarly, in the alphabetized section an invalid ring is found under letter *I* with the identical stock number.

Items that are not stock must be purchased specially. Such items are ordered only upon receipt in the purchasing office of the proper purchase requisition (PF 166B) which has been approved by the department head. Special orders that vary from the standardized items are not purchased.

All sterilized stock (surgical gloves, instruments, and so on) are requisitioned from central supply. Such items are only issued to central supply.

The storeroom is of equal importance in the master control system. All sections have clip boards listing each item kept in each particular storeroom section. They are identical to the categorized section listed in the stock book. Each shelf has markers to indicate the location of each item. The accuracy of the issuing clerks and the master control clerk all enter into the accuracy of the control. If the items are not properly placed in stock or withdrawn, the master control is disrupted.

MEASURING MEASURED ISSUE

"Measured Issue" is an issue to the various departments at a definite time interval in order to keep the departments' stock to a set point. If a department does not have a sufficient amount of stock on hand, time is lost in looking for the needed article, cleaning it, preparing it, or doing whatever is required to bring reusable items back to usage. If, on the other hand, there is an overstock of material, employes are likely to be careless with supplies and equipment. With an excess of stock vital space can be sacrificed. An ideal stock point can be achieved. It is then desirable to keep the stock as close as possible to the ideal point. Different procedures and products used from hospital to hospital will cause the ideal point to vary.

One method of computing the ideal point is to take the mean average of the stock kept on hand by the various departments and build it up or reduce it to this point. This can be done by taking actual physical inventories in the departments at specified intervals. Then a measured issue may be distributed that is the arithmetical average of stock used by the department per time period, allowing for seasonal variations based on a 100 per cent census. The usage records can be used

to determine the arithmetical average. For obvious reasons, a physical inventory is taken at the start and at the end of the period the usage records are being kept to determine the measured issue. Adjustments can be made easily for various unusual circumstances and from actual experience. Miscalculations are also corrected at this time. A sufficient amount of additional stock should be carried in the storeroom to cover emergencies and unforseeable delays in delivery. There are a number of items that are used spasmodically and, of course, these cannot be distributed on the basis of measured issue.

The only successful way of developing a measured issue is through the cooperation of the various departments. Our central supply supervisor was the first to agree to try the system. Through her cooperation we were able to carry it throughout the hospital. By the use of measured issue various departments have saved an estimated 20 hours per week. The time is saved because the department heads and their assistants no longer have to check their stock and write requisitions. The storekeeper has been able to take on the additional duties of sorting the mail, which requires approximately six hours per week.

CORRELATED PURCHASES

Correlated purchase is a system built on long-term purchase orders, that is, purchase orders which cover a period of from six months to one year. The shipments of material then arrive in the same quantities and time periods as the measured issue is distributed. One method of obtaining bids for this type of purchasing is to give a complete explanation of the system to the suppliers, and the expected census for the particular months, with the agreement that the supplies will be either increased or decreased in relation to the actual census.

One of the most equitable methods of obtaining prices on a quotation basis is on a percentage in relationship to prevailing *manufacturer's* published price at time of delivery. There are a number of items which can now be bought direct from the manufacturers. However, we prefer to pay the slight difference required to purchase such material through dealers. We feel the services rendered are more than sufficient to justify the slight additional cost and the dealer is justified in carrying a sufficient stock of minor items.

When one manufacturer of surgical dressings recently released a prepackaged heavy drainage dressing we decided to test it. One of our dealers ordered a sufficient stock to carry us through the test period and the first months of usage. The needs for this dressing were greater than we had expected. Inasmuch as the dealer carried it in local stock and we also had our own test stock, we were able to change to the new product and technic without waiting for shipments from out of town and without changing back and forth between the old and new methods. Thus, with the dealer's help, the change was made with a minimum of confusion. The dealer's service also made it possible for him to sell our personnel on the advantages of a new product which gives the greater service, reduces both hospital labor and material cost, and permits us to render better service to patients at a lower charge.

BID ON EQUAL PRODUCTS

All products are purchased from exact specifications so that all suppliers are bidding on equal products. The receiving department carefully checks all incoming shipments as to product and manufacture. Substitutions are not permitted and will not be accepted by the receiving department.

It should be noted that both the promised delivery date and the actual delivery date were recorded prior to the inauguration of the system. The supplier's ability to deliver as promised is as important a factor as the price in the choice of suppliers. It has been my experience that the best prices and the best delivery can be obtained by bidding a whole line of merchandise at one time, such as all of the paper goods, all of the textiles, and so forth.

Also, if orders are then subclassed and the total bid of the subclass is considered in order that a certain dollar volume may be shipped each month, the shipments and prices will remain excellent. However, when the items are broken down among too many companies, the freight and paper expenses of the companies increase and arrangements may be unsatisfactory to both parties. Of course, all reputable companies should be permitted and encouraged to bid.

The master control cards are used on all stock items, either on measured issue or carried on regular stock. Yellow indicators are used to show the expiration dates of the long-term purchase orders.

ADVANTAGES

Synchronized purchasing can be put into effect in a relatively short time provided there is cooperation from all concerned. The advantages are well worth the effort involved. Departments do not have to worry about routine delivery. There is far less bookkeeping since the deliveries from various vendors arrive at one time so that there are fewer invoices to process. A few companies may balk, at first, if they have never been exposed to such a system. However, they benefit because they can anticipate their sales, they make fewer shipments, and they have fewer invoices to process. When they realize that synchronized purchasing also saves salesmen's time they become advocates of the system.

Synchronized purchasing helps the over-all financial situation of the hospital in that a relatively small amount of cash is tied up in a correspondingly small inventory. Items come in monthly, are billed monthly, and are generally payable the 10th of the following month. These items have actually been resold prior to payment. There is also a protection against shortages in that standing orders take precedence, as a rule, over all others. Most hospital budgets are figured on a census basis and, therefore, with measured issue and correlated purchases the supplies and equipment are maintained in direct proportion to the actual census.

Administration costs of synchronized purchasing are eventually lower owing to the decrease in overhead by the elimination of an unnecessary number of checks, vouchers, ledger entries, remittance advices, and so forth. At Bethesda we were able to eliminate a storage area of 2200 square feet which contained textile storage and the sewing room. The sewing room was moved into the laundry. This saving in space enabled us to move the outpatient clinic from an obsolete building to the area that was formerly required for storage. We were further able to demolish the old clinic building and turn the space into additional parking facilities.

Synchronized purchasing promotes coordination among all the departments because it lessens the burden of administration and reduces the load of the work. It also produces a smoother running, more efficient, and healthier organization.

Nursing Education Heads for Catastrophe

An administrator's program for "overcoming the disastrous effects recent trends in nursing education have had on hospital nursing services"

THOMAS HALE Jr., M.D.
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FROM the point of view of the largest single consumer of graduate nurse services—the hospital, the impact of recent developments and trends in the field of nursing education has been *catastrophic*—and I am using this word advisedly because there is no milder word that can adequately describe the situation. Let me hasten to explain, however, that I am not drawing the conclusion therefrom that all of the recent developments in nursing education are necessarily wrong or should be condemned. The *effect* of these developments, however, cannot be ignored, and if it turns out that the trend is correct and should be maintained, then some new means must be found, and found immediately, which will enable hospitals to continue giving nursing care to their patients. The steady withdrawal of the services of student nurses over the last 20 years has made this next to impossible.

ONE-THIRD OF OVER-ALL COSTS

Hospitals used to provide nursing care to patients almost entirely by the services of student nurses. The patient consequently paid little or nothing for his nursing care, and the student nurse received her educational training at little or no expense. Nowadays, nursing represents approximately one-third of a hospital's over-all costs. In the old days, the student nurses worked hard, much harder than they do now, and they undoubtedly did not receive as well rounded or as complete an educational experience as they are now getting. Some time after World War I, hospitals began to use more registered nurses to supplement the student nurses as a means of giving nursing care to patients. This, of course, automatically increased the cost of hospitalization to the patient, but could be justified on the grounds that he got more and presumably better care. As the trend toward using more registered nurses continued, an opportunity developed for the student nurse educational program to shift somewhat from ward to classroom, and there are definite advantages in the better planned curriculum which has resulted. However, I am less concerned with the rightness or wrongness of this program than with its effects on nursing service in hospitals. It is obvious that as the burden of nursing care shifts from the student nurse to the registered nurse, two results automatically follow: first, the cost of hospitalization increases to the patient and, second, it becomes essential that hospitals be able to obtain a sufficient number of registered (or practical) nurses to care for their patients.

Now, if in the past 15 or 20 years it had been possible for hospitals to obtain *enough* registered nurses to staff their floors seven days a week (which means evenings, nights and week ends, as well as the daytime shifts Monday through Friday), hospitals would probably have somehow or other found the money to do this, and patient care would not have suffered. However, the exact reverse of this has been true; far from being able to find enough nurses to provide even the minimum of good nursing care, hospitals in many cases have not even been able to find enough nurses to keep their wards open. They are driven to desperation in many cases trying to find even a skeleton force of nurses to cover the floors evenings, nights and week ends.

CANNOT ASSIGN STUDENTS

Under similar circumstances in the past, hospitals were able to look to their schools of nursing for assistance, and, although this may have been undesirable from the educational point of view, it did enable the hospitals to meet their primary responsibility of providing nurse care to their patients. Now, however, hospitals have practically nothing to say about the assignment of student nurses, and although this again may be as it should be from the standpoint of nursing education, it has placed the hospitals on the horns of a serious dilemma. They have the sick patients, but they cannot employ registered nurses to nurse them because there are not enough to go around. There is frequently enough "nurse power" in the student group to meet the needs of the hospital for patient care, if students could be assigned to the areas where they are needed at the times when they are needed. The ability to influence such assignments, however, has been taken away from the hospital in most cases.

Let us look for a moment at the purpose of the hospital in a community. Who built it, who contributes toward its support, why does

From a paper presented at the New York State League of Nursing convention, Buffalo, N.Y.

it exist, and what must it accomplish? The primary purpose of any hospital is to provide facilities for the care and treatment of sick or injured patients. This obligation is first and foremost the reason for the hospital's existence. It is an obligation which the hospital cannot share with any other person or agency, nor can it fail in this responsibility without deserting the very principles which justified its being built in the first place. Patients, the public, doctors and local social and governmental agencies not only expect, but have every right to demand, that their hospitals provide adequate and proper nursing care to the patients whom they have opened their doors to receive. Even if the hospital does nothing beyond providing such facilities, it will have fulfilled its *primary* responsibility to the community.

WOULD LIKE TO EXPAND

However, we would hope that the hospital could do more than simply meet its primary obligation. Hospitals would like to provide opportunities for medical students and interns to learn how to become doctors, for nursing students to learn to become nurses, for nurse anesthetists, physical therapists, medical librarians, x-ray technicians, laboratory technicians, dietitians and many other groups of "para-medical" personnel to learn how to qualify for all of these positions and meet the requirements of innumerable certification boards and societies. Hospitals would like to become community health centers in the broadest sense of that term. But the hospitals must do all of these things in addition to giving the best possible nursing care to their patients at a reasonable price, and they cannot perform these functions, or indeed any one of them, if the program they are asked to sponsor in any way detracts from the best nursing care at a reasonable cost. It is right at this point that the impact of the recent developments in nursing education has hit hospitals the hardest and hurt the most.

To give a few specific illustrations of the effect that curriculum changes can have upon hospital nursing service, let me cite the following examples. Again may I emphasize that I am not making the point that these changes are wrong; I am simply trying to show how drastically they have affected the hospital's ability to give nursing care.

1. *Reduction in Work Week.* In a school of nursing with 300 students, a reduction of one hour a week in the time that students are on the wards means a loss of 300 hours a week of nursing time to the hospital. On the basis of a 40 hour week this means that the hospital has just lost the equivalent of more than seven general staff nurses. When one considers the extensive reduction in the work week of student nurses that has taken place in the last 20 years, it is at once obvious that this development alone has caused hospitals to need hundreds — nay thousands — more registered nurses than they formerly did to care for the same number of patients. It is my opinion that this factor alone is more responsible for producing the nursing shortage that exists today than all other factors put together.

2. *Shift From Ward to Classroom.* The tendency to shift from ward experience to classroom lectures and theory is very much in evidence. This trend also results in a reduction in the number of hours a week that student nurses care for patients, and consequently necessitates on the part of the hospital the employment of still more registered nurses (who are not available).

3. *Week Ends.* There is a tendency for student nurse classes to be held Monday through Friday during the daytime. This means that all days off come either on Saturday or Sunday. Consequently, on week ends, when it is most difficult for the hospital to obtain registered nurses to care for patients, the student nurses are not available for assignment.

4. *Evenings and Nights.* Here again the hospital has an extremely difficult time employing registered nurses for these unpopular shifts. At the same time, the trend in nursing education is to refuse to allow students to be assigned to evenings and nights, with the result that many hospital wards are closed simply because no nurses can be found for one of these two shifts, even if there is adequate nursing power to staff the ward during the remainder of the 24 hours.

5. *Vacations.* The tendency toward more liberal vacations for student nurses results in their being that much less available to care for patients. Vacations which were formerly staggered are now sometimes given to the whole class at once. When a class of 50, 75 or 100 student nurses leaves on the same day for a vacation, hospital nursing service receives a serious blow.

6. *Utilization of Student Nurses.* Hospitals used to utilize the services of student nurses in responsible assignments in the operating room and in charge of wards during their senior year. The tendency in nursing education is to frown upon such assignments, thus forcing hospitals to employ registered nurses for these positions, formerly filled by student nurses.

7. *Number of Patients Cared For.* Student nurses used to be assigned to a floor, and shared with the floor nurses the patient load on that particular day. Now there are limitations being placed on the number of patients a student can care for, without regard to the needs of the floor at that particular time. The already overburdened floor nurses must care for the additional patients formerly handled by the students.

HAVE OUTSIDE PROJECTS

8. *Nonservice Assignments.* The tendency in nursing education is to enrich the experience of student nurses by assignment to areas in the hospital, or outside the hospital, not directly concerned with the care of bed patients. Examples are: assignment to Visiting Nurse Association, diet kitchen, child health clinic, maternal guidance clinic, nursery school experiences, schools for physically handicapped, family care programs in outpatient departments, and a host of other worth-while projects. Every such assignment, however, takes the student nurse away from the bedside of the patient, where formerly she was providing nursing care.

9. *Preclinical Period.* Preclinical periods which formerly were three months in length and were divided between classroom and ward experience have now been extended to six, seven, and in some cases eight months, almost entirely restricted to classroom work. Here again the demands of the curriculum for more theory and classroom exercises are invariably at the expense of ward experience.

10. *Sick Leave.* In the past, girls who were sick were required to make up their time lost. Now the tendency is to allow more sick time without makeup. Here again in a school of 300 nurses, if each has only one sick day a year without making up the time, the hospital loses 300 days of nursing care, and if each girl should

have as much as 10 sick days without makeup there would be 3000 nursing days lost to that hospital. Even assuming that only a four-hour day was lost, it would take six full-time nurses added to the staff to compensate for that loss.

These are only a few examples, but they suffice to illustrate how the developments in nursing school curriculums over the past few years have *in every case* resulted in lost service to patients in the hospital. Whether or not these developments are good or bad is not for me to say here. But it should now be more clear why I say that the *effects* on hospital nursing care of recent developments in nursing education have been no less than catastrophic.

Before proceeding further, I would like to point out that I am not laying on the doorstep of nursing education the full responsibility for the nursing shortage. There are many other factors involved, with which we are all fully acquainted. Among them I might mention the hospital expansion program which in the last eight years has added thousands of beds to be served by nurses, the increased use of nurses by industry and public health agencies, the shift to a 40 hour week in most hospitals, the additional demands on nurses' time owing to more complicated medical procedures and treatments, the demands of the armed forces, and the fact that nurses are now carrying out many procedures formerly done by doctors.

All of these factors have played their part in producing the present nursing shortage, but over and beyond all of these there is the loss of the services of nurse students, a factor which has received little public attention, but which is of prime significance in making it difficult for hospitals to give adequate nursing care to their patients. As I have stated, this movement may or may not be defensible from a strictly educational point of view—I do not wish to debate that point right now—but its effects on hospital nursing services have been practically atomic.

At the same time that the services of student nurses have been withdrawn from hospital patients, the cost of supporting a school of nursing has steadily and rapidly increased. If the withdrawal of student nurse services had been accompanied by a comparable decrease in expense, and if at the same time enough registered nurses had been available so that hospitals could have employed them and continued to give good nursing care, hospitals could somehow have continued to exist and meet these added costs.

However, all of the changes enumerated previously, and all of the other changes which have taken place in nursing education during the last 20 years, have *increased*, rather than decreased, the cost of operating a school of nursing. From the time in the early days of this century when the patient paid almost nothing for nursing care, it has now reached the point where the patient not only pays in full for his nursing care, but in addition pays a substantial amount for the support of the nursing school over and above any services rendered in return. All hospitals which have made cost studies of the operation of their schools have discovered that after giving due credit for every hour of time spent by student nurses in caring for patients, there is still a deficit averaging between $500 and $1000 per student, per year, which the hospital is paying for the support of the school. It is perfectly obvious that patients cannot go on paying more and more for less and less service.

What then are the solutions to this problem, and what can be done about it? Should we turn the clock back and let hospitals assign students where needed without regard to their educational experience? Certainly not! I have a positive program to suggest, and it is relatively simple. It does not involve any new experimentation, which is both time consuming, expensive and, in this case, unnecessary. It could be put into effect tomorrow, and in a reasonable period of time many of the hospitals' problems involving nursing care would be solved. As a matter of fact, there is nothing new in this program; it is already in effect in varying degrees throughout New York State at the present time. If it could be accepted wholeheartedly, and backed wholeheartedly, by the state nurses' association and the state league for nursing it could produce outstanding results in a minimum period of time.

This program may be divided into three parts:

1. A recognition that there are *three levels of nursing* needed in hospitals today, and a determination

Nursing Calls Housekeeping Blessed

IVAH V. YETMAN, R.N.
Nursing Arts Instructor
Butterworth Hospital, Grand Rapids, Mich.

IN A series of articles that are currently appearing in The MODERN HOSPITAL, Emily C. Deming, executive housekeeper of Butterworth Hospital, Grand Rapids, Mich., explains how she teaches her housekeeping employes, particularly the housekeeping aides who clean and make up patients' rooms.

Since the nursing department has been most immediately affected during the "growing pains" period of the housekeeping training program, it seems important to review it from the standpoint of nursing. How does housekeeping look to nursing?

During my nursing school days I must have been very ambitious, because one of the most irksome things I encountered was to have to learn how many various situations were handled by housekeeping. "Call Housekeeping" was the pat answer to numerous occurrences, without any other explanation. Since, by and large, hospital housekeeping and laundry were a mystery to me, it didn't make sense. I wanted to handle all situations myself.

Over the years, I went from a large state hospital to a smaller community institution. And linen grew to be a controversial subject. The hospital laundry was still a mystery, but it was the laundry which sent up the linen for each unit. However, if a certain item was lacking in the linen closet, nothing, it seemed, could induce whoever was down in laundry or housekeeping to give us an extra piece.

Finally, after several years of skir-

(*Continued on Page* 160)

of the relative numbers of nurses needed in each of these three categories. I am referring to (a) the practical nurse, with one year's preparation, (b) the registered nurse with three years, and (c) the professional nurse (collegiate nurse) with four, five or more than five years of preparation. I use the word "preparation" here in its broadest sense to include all of the educational factors involved. I have heard many people say that the need for nurses is not a need for more registered nurses but a need for more college trained nurses, and that if this need for collegiate nurses was satisfied, the rest of the problem would take care of itself. In my humble opinion *nothing could be farther from the truth.* Although I am fully aware that there are some shortages in the ranks of nursing school faculties, and to some extent in all teaching and supervisory categories, and although I agree completely that this need should be met, nevertheless there is 20 or 30 times the need for general staff nurses today than there is for teaching and supervisory personnel. Let me give you one specific example from my own bailiwick in Albany. All during the summer of 1953 there were two vacancies on the faculty of the nursing school with which we are affiliated, but there were more than 60 vacancies for general staff nurses to take care of our patients. At the present time there is one vacancy on our faculty, but there are more than 35 vacancies on our general staff. This experience could be duplicated in almost every hospital throughout the state. Surely we must produce enough highly trained nurses to fill all vacancies at the top, but you cannot fight a war without privates, and you cannot run hospital wards without enough floor nurses, whether registered or practical, to care for the patients.

Practical nurses can be produced, with three months preclinical training and nine months of clinical training, who can quite effectively handle the bulk of actual bedside care in any hospital. I speak from many years of experience, because Albany Hospital has had a large group of practical nurses on its staff since long before I came to Albany. These nurses give excellent bedside care to patients, and can carry the major share of such care very satisfactorily. Practical nurse students can also provide a suitable amount of sound nursing care for patients while they are in training. At Albany Hospital we have an affiliation at present with a practical nurse school, and its students have given good patient care when they have reached our wards. Practical nurse schools can be sponsored by high schools, by adult educational programs in the high schools, or by the hospitals themselves.

Registered nurses, trained in hospital schools of nursing, in the regulation three-year period, are fully capable of giving treatments and medications, acting as team leaders with practical nurses, student nurses, and nurse attendants in the team concept of nursing care, and taking charge of wards as head nurses or assistant head nurses. For these latter positions they need on-the-job training programs in supervisory and administrative technics. They do not need a college background.

College trained nurses can best fill teaching and administrative positions in schools of nursing, and to some extent supervisory positions in nursing service.

WHAT IS PROPER RATIO?

Now, the big question to decide is the proper ratio of these three types of nurses. Enough nurses should be trained in all three categories to meet the needs, but no one group should be favored at the expense of the other two. Numerically speaking, from the point of view of hospital and nursing school needs, approximately 10 per cent of all nurses should be college trained, about 45 per cent should be R.N.'s, and about 45 per cent should be practical nurses. These figures will vary somewhat from hospital to hospital, but the actual needs for these different categories of nurses should approximate those averages.

2. It would be thoroughly desirable if some form of *progression* could be developed in the field of nursing education so that a practical nurse could advance to become an R.N. without having to start over again and take the full three-year course. In the same way an R.N. should be able to advance herself by study so that she could hope to be eligible for faculty and supervisory responsibility if she proved capable. I am aware that the National League for Nursing is concerned with this particular problem at the present time, and I am sure it presents many difficulties in its execution. Its solution, however, would go a long way toward aiding recruitment in the two lower groups of nurses.

3. As long as there is such a severe nursing shortage as now exists, I think that those responsible for nursing education should not press for curriculum and administrative changes in hospital schools of nursing which continue to withdraw from the hospital more of the services of its student nurses. There are many safeguards which have already been set up to ensure that the student gets a well rounded educational experience. These safeguards should be kept. I would hope, however, to see a reversal of the recent trend toward a constant diminution of the services that students can render.

Patients in most hospitals are dependent on student nurses for anywhere from 40 to 80 per cent of the care they receive. In our own hospital, 50 per cent of all nursing care is given by students. Students should be taught to feel proud to render such a service to patients in their community hospitals while they are learning to be nurses. They should feel proud that they are able to earn all or most of the expenses of their education by rendering such services. It is far better for them to earn while they learn, instead of making it necessary for hospitals to tax patients to pay for their education, as an alternative to getting financial assistance from the government. In Albany Hospital last year, student nurses earned $318,393 by their services to patients. Why should federal, state or local governments have to supply this money out of tax funds?

Here is the program then:

1. Encourage the development of practical nurse schools in high schools and hospitals, and the use of P.N's. in hospitals.

2. Do not change or abolish the three-year hospital school turning out R.N's. Recognize that compromises have to be made with the nursing service needs and always will have to be made.

3. Limit the collegiate school program to a small percentage of all nurses. Relax the pressure which is being put on hospital schools to become collegiate schools.

4. Develop a system of progression so that nurses could advance from one group to another without starting all over again at the bottom.

5. Recognize that it is sound economics and sound character building to encourage girls to "earn while they learn."


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VOLUNTEER FORUM

Seeking to improve its community relations, this hospital turned to women volunteers for help, and now

Members of the children's committee entertain a "client."

Sutter Hospitals Have 500 Ambassadors

BARBARA B. MACKEY **JOHN A. RUDD** **CHARMIAN W. SHRADER**

IN SEPTEMBER 1952, the board of trustees of Sutter Hospitals, Sacramento, Calif., decided that an expansion program was necessary to cope with the increase in population and resultant waiting list for admissions. On the recommendation of a public relations specialist for a nationally known fund raising organization a women's auxiliary was organized to aid the hospitals in improving their public relations and to bring to the local citizens a better understanding of the hospitals and their relation to the community.

A meeting on Jan. 7, 1953, culminated a series of efforts to interest the women of Sacramento in organizing this auxiliary. At this meeting, it was proposed that a provisional committee be formed for the purpose of obtaining permanent officers and of starting a membership drive.

Following this meeting, the campaign counselors met with the various committees, helped them write by-laws modeled on those suggested by the American Hospital Association, planned successive meetings, and encouraged them on those occasions when the task appeared to be overwhelming.

Each of the 28 founding members was asked to bring 10 other prospective members to a meeting at which the aims and objectives of the auxiliary were to be explained and a permanent organization formed. This meeting was attended by 260 women, of whom 254 signed for membership. The permanent organization elected as its new president Mrs. Raymond O. Mackey, who had served as chairman of the provisional committee. By-laws of the auxiliary stipulate that officers may serve only two terms of one year each and the board members, two terms of two years each. Volunteer service is open to anyone in the community, regardless of race, color or creed, who is interested in the group's aims. On the advice of the fund raising counselors, it was also decided that the auxiliary should be incorporated so that any liabilities that might be incurred would not devolve upon any individual members. Within six weeks after the organization meeting, paid membership reached a total of 500.

As soon as the organization became official, a series of classification interviews was arranged. Women whose names had been submitted as prospective members were asked by letter to attend an interview session and, by careful organization, delays and waiting time were reduced to a minimum. A committee did an excellent job of assigning the interview times and reassigning those who failed to appear when called.

The women who were to do the interviewing were hurriedly briefed on their responsibilities and were given an outline of proposed volunteer services to be accepted by the auxiliary. Thus armed, they undertook to record on printed classification cards the varied experience, training, avocation and desires, as well as the hours of availability, of the applicants who appeared before them. This system worked well enough during the first three weeks and served to clear the big log jam of initial applications, but it was quickly found desirable to slow up this process and take time to assess the results being obtained. This was implemented by the early discovery that there were some highly trained professional people among the applicants, including social workers, educators, radio personalities, business executives, merchandisers, librarians, even a newspaper editor and a complement of artists.

From the beginning it had been advised that no volunteer service within the hospital should be performed by any member of the auxiliary until the volunteer had passed an orientation course, obtained her uniform, and paid her dues of $3.

It was made plain that volunteers would be serving on the floors of the hospitals with professional people who had high standards of ethics and of job performance and that they must, individually and collectively, try to measure up to similar standards. There were some complaints, of course, but the esprit de corps that was rapidly generated amply justified the delay in starting and the insistence upon a simple form of discipline.

The orientation course was set up by Mrs. George F. Aughinbaugh, who

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At the time this article was prepared, Mrs. Mackey was president of the Sutter Hospitals auxiliary, which she helped to found. Mr. Rudd, now regional director of the Texas Heart Association, was a representative of the fund raising counsel. Mrs. Shrader is the current president of the auxiliary.

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Above: A customer watches as a snack bar volunteer fills her order.

Administrative committee members.

Teen-agers formed a junior auxiliary.

The gift shop was worth all the effort that went into its construction.

Distribution of Volunteer Services at Sutter Hospitals

Service	No. of Shifts per Week	Volunteers on Each Shift
Chairman of the day	5	1
Children	10	2
Gift shop	27	2
Information	27	2
Library	5	2
Office	10	1
Snack bar	10	1
Shortly after completion of Mrs. Mackey's term of office as president, the following two services were installed:		
Errand Aims (at Sutter Maternity)	5	2
Next-to-New Shop	6	2

From Feb. 16, 1953, to May 31, 1954, a total of 21,933 hours of service in both hospitals had been accumulated by all services. Including the two newer services, a total of 570 hours per week are now being served.

had established the orientation and training of U.S.O. volunteers during the war and had been responsible for orientation of civilian workers at McClellan Field. Mrs. Helen Brownell, the assistant administrator, worked closely with the committee in her capacity of coordinator of volunteer services in the hospitals, and Mrs. John A. Rudd, a former social work administrator and executive secretary of the Florida Conference of Social Welfare, made her experience available in an advisory capacity. Mr. Rudd, representing the fund raising counsel, had made a study of the manpower needs of each of the proposed services, based on the suggested three-hour tour of duty and on service in either one of the hospitals or both. Each service chairman was presented a copy of this for guidance.

Since it would be impossible for all service chairmen to be available every day to handle the emergencies that would inevitably arise, a number of captains of the day (COD's) were appointed, one of whom would always be on duty. They were empowered to act for the service chairmen when necessary and could take whatever steps were needed to fill unexpected vacancies in a service if the volunteer scheduled to work failed to show up or to supply a substitute.

The first of the orientation classes was held for the information service and with this group we included the administration service, the captains of the day, and all committee chairmen. Subsequent series, at weekly intervals, gave orientation to the snack bar, the children's service, the library, the gift shop and flower service. Each course included two sessions with Mrs. Brownell, who outlined the relationships of the several hospitals in Sacramento to one another, described the different types of hospitals, the organization of Sutter Hospitals, and their history and future plans. She developed the responsibilities of a volunteer and discussed the code of ethics, then gave a tour of the general hospital. The third class was given by the chairman of the service concerned to the volunteers of her own service. Each volunteer was then presented with the badge of the American Hospital Association for auxiliaries. During this time, each member had procured her uniform in the recommended cherry red, and was able to report for duty complete with badge to indicate successful completion of the orientation course and full accept-

ance into the auxiliary. The first course proved too rigorous and later courses were shortened, to great advantage.

In an effort to stimulate membership, especially among the women who worked during the daytime, a speakers' bureau was established under the direction of Mrs. Andrew M. Henderson. She made many talks before sororities and women's groups and arranged others for the speakers' bureau members. The success of staffing evening and week-end services of the auxiliary is directly attributable to her efforts in this direction. For the continuing success of recruitment, this bureau became a permanent part of the auxiliary's public relations work.

Another large contribution to the success of the auxiliary's operations was the organization of the junior auxiliary in October 1953. This was composed of 65 teen-age girls who wore pinafores in the uniform color and who also passed an orientation course before being allowed to serve. The juniors wrote their own by-laws and elected their own officers. They pay dues of $1 a year. The special function of this group is to design and make tray favors for patients at holiday times.

Fred R. Murphy, administrator of the hospital, had promised that the profits from the snack bar would be turned over to the auxiliary, even though it was a hospital operation, when the volunteers undertook its supervision and provided help to staff it. This was averaging $450 per month and was of great assistance in putting the auxiliary on its financial feet. In addition, the board of directors of the hospitals made an advance of $1000 which enabled the auxiliary to employ an office secretary to direct volunteer activities in the office and to give continuity to the administrative operations during the early months of organization.

Above, left: Fixing up the resale shop.

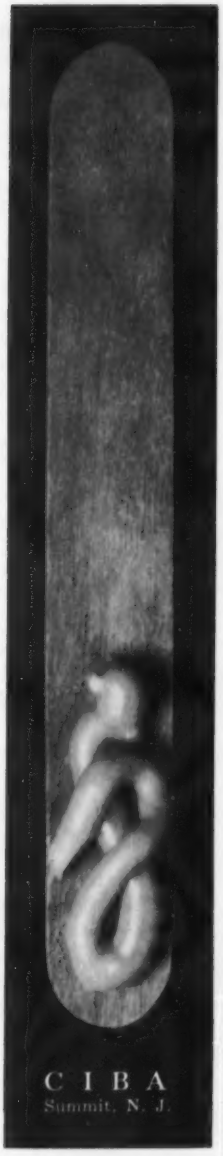
Above, right: Library cart starts its rounds.

Left: Information is an important service.

Below: "Flower girls" are welcome visitors.

In Sutter General there did not seem to be any place for a gift shop—after all, the building fund campaign was made necessary by lack of space! However, one was needed and Mr. Murphy and Dr. Milton Sarkisian, president of the board of trustees, saw to it that space was made available. This was done by wrecking what was originally a vault which had very thick concrete walls. During all this time, there had been a picket line around the hospital because a labor union wished to be named representative of the nonprofessional employes. The employes themselves, or a majority of them, were not in favor of union representation but the picket persisted. When the time came to bring in workmen to wreck the vault, it was found that union men could not cross that picket line. At once, Dr. Sarkisian, Mr. Murphy, Mr. Lundgren, the office manager, and others donned operating room masks and overalls and operated a compressed air chisel themselves on Saturdays and other off hours. The concrete was exceptionally hard and it was necessary to resort to small charges of dynamite to make any impression on it. This, of course, necessitated removal of patients from the floor above while work was in progress. After all this trouble, the success of the gift shop has been doubly gratifying. At the end of its first year of operation $1750 was turned over to the general operating fund, over and above the amount that was invested in stock for Christmas shopping.

The auxiliary's services had not, up to March 1954, included Sutter Maternity Hospital, which is located several miles from the general hospital. Visitation to mothers there is restricted to husbands and the afternoons are long for patients. One of the staff doctors, who has a machine shop, made a cart with magazine racks on one side and shelves on the other. He donated the cart in appreciation of the auxiliary's services. Six days a week two



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volunteers visit the mothers and provide them with all those necessary items the new mother is likely to forget to bring with her.

It was an exciting day in March of 1954 when two of the volunteers found a charming little run-down bungalow that had formerly been a dance studio in an old section of Sacramento. What were they looking for? A location for the "Next-to-New" Shop. Days of work for husbands and wives followed. Anyone who was not covered with pink, black or white paint just didn't belong to the auxiliary. Construction of dressing rooms and shelves, paint, sink tiling, linoleum, signs and display cases were all donated. On April 26, a cocktail party honoring these contributors was held by the shop committee. The hospital board and auxiliary board were invited. In its sixth month of operation, the shop netted $450 and sales are mounting each day. On the most prominent wall of the shop is a large sign showing a picture of each service in the hospital. Above this is a sign which reads: "The proceeds of this shop are used to maintain the services to patients of Sutter Community Hospitals depicted below and for the Philanthropy Fund of Sutter Hospitals' Auxiliary, Incorporated."

The most rewarding philanthropy was instituted Oct. 15, 1954, under Mrs. P. S. Willard, philanthropy committee chairman, after months of preparation. A questionnaire was sent to all general practitioners and pediatricians on the staff asking what type of help was most needed by their patients. The results showed that the parents found the expenses of premature infant care difficult to meet, particularly as they are usually unprepared for them.

With the approval of the general membership, a letter was sent to these doctors stating that a noninterest bearing loan fund was to be used to defray the expense of room charges for extra postnatal care for premature infants born at Sutter Maternity Hospital. The staff doctor recommends needy cases to the committee which consists of seven members. One of them is a doctor on the pediatrics committee, and one is a Sutter Hospital staff adviser. The memorial fund is also handled by this committee and proceeds from it go to the philanthropy fund treasury.

The auxiliary office was opened on Feb. 16, 1953. By July 29 of that year, there were seven services in full operation. Distribution of these services is shown on page 100.

Toward the end of the fund raising campaign, it was suggested that the auxiliary, as one of the organizations within the community, consider making a treasury contribution of $7500 to the hospital building fund, the money to be used to cover the cost of the auxiliary room. The membership approved but it was difficult to see how this amount could be paid in a period of three years. Thereupon Mrs. Shrader asked the hospitals' board of trustees for permission to spread the pledge over five years. The trustees granted the request without hesitation and accompanied the motion with some highly complimentary comments on the progress of the auxiliary and their opinion of its value.

The auxiliary's first fund raising effort, apart from day-to-day operations, was the sponsoring of a concert by Claude Rains. Although this was a financial success, the volunteers all vowed "Never again!" The worry, the hard work, and the headaches were not worth the financial return.

That the auxiliary was fulfilling its purpose as a public relations outlet for the hospitals rapidly became evident as it grew. At the beginning fear was expressed that the organization was being built up only to solicit funds in the forthcoming campaign. It was almost the first question asked by applicants at the classification interview and some women were never quite satisfied that it was not the case. Later, when the men were recruiting workers for their various divisions of the campaign, they reported that they invariably found great interest in the hospitals' affairs, a much greater knowledge of the needs of the hospitals, and more understanding of the problems which had given rise to the bad publicity than had ever before existed.

The value of the auxiliary to the hospital in building community understanding and good will, as well as in raising money, is summed up in the accompanying statement by Administrator Fred R. Murphy. It is an expression of appreciation and confidence which amply rewards the volunteers for their time and efforts.

DURING the 30 years of its existence, Sutter Hospital has been guilty of the tendency so often found in hospitals of isolating itself from the community.

Because of this, we did not enjoy good press relations, nor did we have any other means of communicating our hospital story to the public.

Owing to our reticence in this regard and the vociferousness of those who might, for one reason or another, feel unkindly toward the hospital, our public relations reached a very low ebb.

The high quality of care being furnished our patients had little or no effect upon this adverse public opinion.

Less than two years ago, with the assistance of a fund raising organization, a women's auxiliary was formed at the Sutter Hospital.

Good judgment was used in selecting the nucleus around which the organization was formed, with the result that the growth and enthusiasm of the group was nothing short of miraculous. At the peak, the membership totaled about 600 and has since settled back to a steady figure of between 400 and 500 members.

The change in community attitude and acceptance of the hospital has been just as miraculous.

The services usually performed by a women's auxiliary are performed by ours and this is of real assistance and is appreciated by the management.

The most important benefit, however, and one which cannot be measured in hours worked or dollars made, is the channel by which the true hospital story is being carried to the community.

Our auxiliary, in addition to all else it has done for the hospital, is an army of 500 ambassadors of good will who go out into the community, in fact they are the community, and carry the true story of Sutter Hospital.

It would be foolish to say that a women's auxiliary in a hospital was without its problems, because there are many, some of which are difficult of solution. But they can be solved and any effort spent in this direction comes back a hundredfold in benefits to the hospital.—F. R. MURPHY, *administrator, Sutter Community Hospitals, Sacramento, Calif.*

Questions Concerning the Medical Audit

LUCIUS W. JOHNSON, M.D.
San Diego, Calif.

THE increasing interest in medical audits and, especially, the activities of the Joint Commission on Accreditation of Hospitals, have evoked a number of questions from administrators and medical staff members as to just what a medical audit is, how and by whom it should be made —and is it good or bad?

In this article, an attempt is made to answer the most frequently asked questions relating chiefly to the "what" of medical audits. Next month Dr. Johnson will cover questions on how and by whom the audit should be made and how the hospital and staff can make the proper use of the results of the audit to improve standards of patient care.—Ed.

1. What is a medical audit?

It is a device for appraising the quality and the results of the professional care in a hospital. It reveals the true character of the institution; evaluates the ability, loyalty and attitudes of each member of the medical staff; measures the excellence of the administration; estimates the interest and the activity of the governing board; gauges the morale of the workers on all levels; surveys the public relations of the hospital.

2. What has caused the recent increased interest in audits?

A dozen or more derogatory articles about doctors and what they do in hospitals have been published in general magazines and in the press. They have brought accusations of unnecessary and incompetent surgery, ghost surgery, fee splitting, kickbacks and other clandestine financial deals. As one result, hospital trustees have come to realize that they are responsible not only for the business and financial details, but also, legally and morally, for the quality of professional care provided for the patients. The audit has proved to be one of the most valuable devices by which trustees can be assured that good professional standards are maintained in their hospitals.

3. What are the objectives of the medical audit?

To measure the quality of professional care in the hospital.

To assay the competence of each doctor and his value as a member of the hospital team.

To bring to the attention of the hospital group any deficiencies in patient care that may be discovered, with suggestions for their correction.

To determine what sort of jobs the administrator and the trustees are doing.

The basic beliefs on which the audit is founded are: (a) The vast majority of physicians are competent and conscientious in their work and their relations to the patients and the hospital; (b) as they represent a cross section of the whole people, there are a few whose activities must be restrained for protection of their patients, and (c) in every profession, trade or following there must be some authority to detect and correct trends toward low standards. In the hospital, the organized medical staff carries this responsibility.

The audit can also provide answers to questions like these:

How thoroughly does the hospital group investigate the training, ability, identity and credentials of candidates for staff privileges?

Are the educational programs what they should be?

Are there abuses of Blue Cross or other insurance?

Is it true that private patients get poorer care than others?

Is the hospital's organization for disaster adequate?

Are the diagnostic services adequate?

Are the charter, by-laws, rules and regulations suitable? Do they provide a firm foundation for restrictive action?

Does the hospital fill the needs of the community in size, type and organization?

How can public relations be improved?

Does the desire for the welfare of the patients dominate?

Do personnel policies assure good morale in the workers?

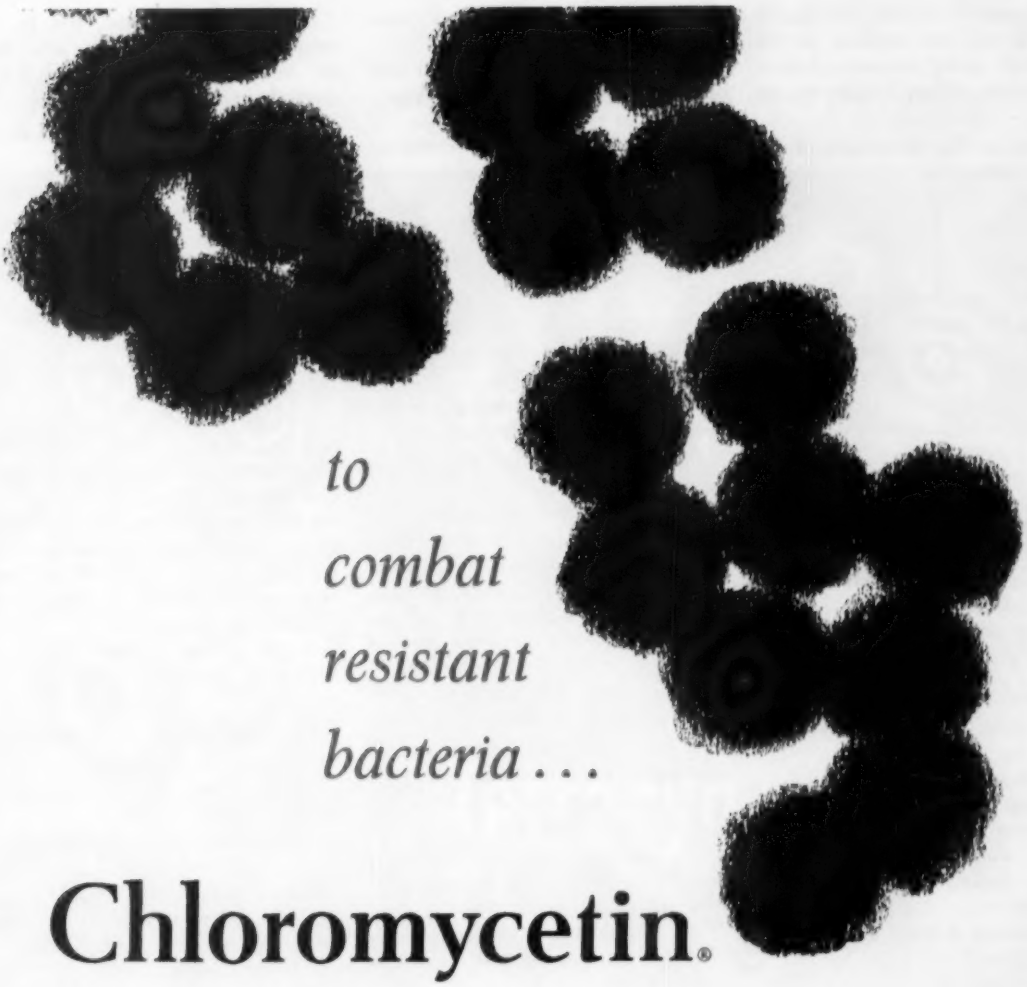
Is a cancer clinic or tumor board needed?

Are physicians careful to protect the hospital and themselves against suits for negligence or malpractice?

4. Is there more than one type of medical audit?

Yes. There are two principal types: The first is the continuous audit, conducted by committees of the hospital's own medical staff. They study the treatment and the result, as shown in the clinical record of each patient. Periodic reports are made to the organized staff with recommendations for any action that may seem suitable.

Second, there is the audit by a qual-



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The rising incidence of bacterial resistance to various antibiotics constitutes a serious therapeutic problem. Many infections, once readily controlled, are now proving difficult to combat. Administration of CHLOROMYCETIN (chloramphenicol, Parke-Davis) is often useful in these cases because this notable, broad-spectrum antibiotic is frequently effective where other antibiotics fail.

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CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

*Pratt, R., & Dufrenoy, J.: Texas Rep. Biol. & Med. *12*:145, 1954.

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ified, independent outsider. He studies the records and the working of the hospital and makes recommendations for correction of any deficiencies he may find.

5. What are the advantages of the continuous self-audit?

Hospitals that use it have listed them as follows:

To the patient:

It ensures that careful preoperative study will be made.

Private patients receive the same careful study as do those used for teaching.

Critical evaluation of results benefits future patients.

Abuse of narcotics and antibiotics is made clear.

Incompetent and ill-advised practices are eliminated.

Operations of dubious value are reduced in number.

Physicians enjoying unmerited privileges are restrained.

To the medical staff:

The quality of self-discipline is improved.

Practice of scientific medicine is encouraged.

Privileges are based on merit and quality of work.

Public relations of hospital and doctors is improved.

It is the best defense against socialized medicine.

To the hospital:

Chiseling on Blue Cross and insurers is reduced.

Defects in by-laws, rules and regulations are made clear.

Unfavorable end results are reduced by careful study.

Trustees are assured of high professional standards.

Deficiencies in equipment and administration are shown.

Teaching programs are facilitated.

Chances for accreditation are improved because deficiencies which can be corrected are revealed.

Public confidence in the hospital is increased.

6. What are the disadvantages of the continuous self-audit?

High cost, which may approach that of the financial audit.

Fears that competitive jealousy may affect the results.

Increases clerical load on hospital and physicians.

Doctors enjoying unmerited privileges may obstruct it. They may resent definite privileges and controls.

Profits of doctors and hospital may be reduced by limiting unnecessary and dubious procedures.

It may offend doctors on whom the hospital depends for profitable operation.

Records may be subpoenaed as evidence in law suits.

Prestige of some doctors may be damaged.

The audit may be obstructed unless the medical staff is convinced of its value and integrity.

7. What are the advantages of the audit by an independent outsider?

In addition to those listed under question No. 5, they are:

Suspicion of personal interest and professional jealousy is averted.

It can be a valuable aid to better public relations if it is properly advertised to the community.

There is always the hope that the hospital staff will be so convinced of the value of the audit that it will adopt the continuous self-audit.

8. What are the disadvantages of this type of audit?

In addition to those listed under question No. 6, they are:

The results may be embarrassing to some of the most active and aggressive members of the medical staff.

If the recommendations are not carried out, the hospital will not get its money's worth.

9. What should be the qualifications of the independent auditor?

He should be a graduate in medicine with long experience as a member of medical staffs in hospitals.

He should have had experience in hospital administration and be familiar with the business, administrative and professional problems common to hospitals.

He should be free of local affiliations, social or other obligations to any member of the hospital group.

He should be of a temperament that will allow him to maintain an impersonal attitude, with attention centered on the welfare of the patients in the hospital.

He should be able to recognize and commend favorable details while pointing out the unfavorable ones.

He should keep in mind the dangers of the critic's position—the inflated ego and the sense of power that it brings. The best defense against these is to be aware of the danger.

He should understand, and be in complete sympathy with, the aims and the requirements of the Joint Commission on Accreditation of Hospitals.

10. What is the relation of the audit to accreditation?

They are completely independent activities. Most hospitals that employ an auditor do so with the expectation that he will detect deficiencies that might reduce the chance of earning accreditation, and point the way to correcting them before the representative of the Joint Commission makes his examination.

The fact that the hospital group is willing to spend important money for self-criticism, to uncover its deficiencies, is an index of its desire to provide the best possible care of its patients. It is possible that the examiner for the Joint Commission will be favorably impressed by this evidence of the benevolent attitude of the hospital group *if* he finds there really has been a sincere effort to correct the deficiencies.

11. What are the main weaknesses of the audit by an outsider?

Its whole purpose may be defeated by the appointment of weak, incompetent, indifferent or antagonistic members to the staff committees. Unless the medical staff is convinced of the value and the integrity of the audit, there will be little chance of carrying out its recommendations.

In hospitals with considerable deficiencies some members may prefer to continue the convenient and profitable status quo. They may be powerful enough to block all action for change.

The audit may be most ardently desired by the governing board, advised by the administrator. Striving to bring professional practice in the hospital up to the standards advocated by leaders in the medical and hospital fields, they may lack the sincere support of the medical staff. This support is vital to success.

The auditor may fail to detect the dilatory entries, made perhaps weeks or months after the recorded dates; also the entries which describe symptoms, findings and procedures that do not accord with the facts.

It has happened that staff members were able to arrange to have their most damaging clinical records withheld from the auditor.

It can point out ethical faults of individual staff members, but action

on these is a matter for the medical society.

It is most strongly opposed by those who fear they may lose privileges that they realize they do not deserve.

Those whose feelings or prestige are hurt by the report of the audit will advocate that it be filed and forgotten.

12. What committees of the staff are needed to carry out the recommendations of the audit?

Executive committee: It decides most of the problems of the organized staff and reports its actions in staff meetings. It coordinates the work of all departments by receiving, studying and acting on reports of subordinate committees. It works with the governing board when there is no joint conference committee.

Credentials committee: It investigates the background of training, education, experience and ethical character, also establishes the identity of each applicant for staff privileges. It recommends what privileges new members shall have. If there are no departmental committees, it may study and recommend changes in staff privileges.

Departmental committees: In each department the committee organizes the professional work, controls its quality, and makes recommendations concerning privileges to be granted those doctors who work in the department. It makes suitable recommendations to the organized staff.

Medical records committee: It examines all clinical records, checking on their quality, accuracy and promptness of completion. It lists and notifies delinquent members, also recommends action in conformity with provisions of the by-laws.

Tissue committee: It investigates cases in which normal tissue has been surgically removed and recommends suitable action when indicated. It compares preoperative diagnoses with findings and postoperative conclusions. It considers matters brought to its attention by the pathologist or departmental committees that may affect the quality of the professional work.

Joint conference committee: It studies administrative policies, conduct of the professional work, and all sources of possible friction between the groups that work in the hospital. It acts to keep all hands informed of hospital needs, problems and policies.

Audit committee: If the continuous self-audit is used, this committee is in charge of it. It reports to individual doctors, and to the organized staff, concerning the quality of the professional work.

13. What are the national standards against which the hospital should contrast its own work?

Autopsy rate.....minimum 15%
Anesthetic deaths....not over 1 in 5000
Cesarean sections.....not over 3 to 4%
Infant mortality rate....not over 1.9 %
Maternal mortality rate.....0.25%
Total death rate.....not over 2.5 %
Postoperative death rate
.....not over 1.0 %
Postoperative infections
.....not over 1.0 %

Many excellent hospitals prepare a monthly, also an annual, report to the governing board and the medical staff, contrasting the data in the hospital to these national standards. It helps greatly in pointing out weak spots.

14. What are the commonest causes of friction in the hospital, as seen by the independent auditor?

The players don't know the rules. Too often, members of the staff are not well informed about the provisions of the hospital charter, by-laws, rules and regulations. Many doctors have only vague ideas about what is good administrative practice, what are their obligations, and the limits of their authority.

Each player wants to be his own umpire. It is a sure guarantee of friction when doctors and administrator make their own self-serving decisions in that vaguely defined field that lies between them.

The medical staff fails in self-discipline. It neglects control of members and their professional work. It allows abuses to continue until they cause serious dissension within the staff. Dislike of doctors to criticize their colleagues, or to be criticized, is a common weakness that splits many staffs.

The medical staff is not well informed of the advantages of accreditation to the hospital, to the patients, and to the staff. It regards this as an unimportant detail, one that the administrator should handle. It does not realize that the work and the attitudes of the medical staff are the vital factors in earning or failing to earn accreditation.

Friction may be deliberately inspired, augmented and broadcast to the community by one or more of three aggressive groups: First, those who wish to bring all medical and hospital practice under the control of

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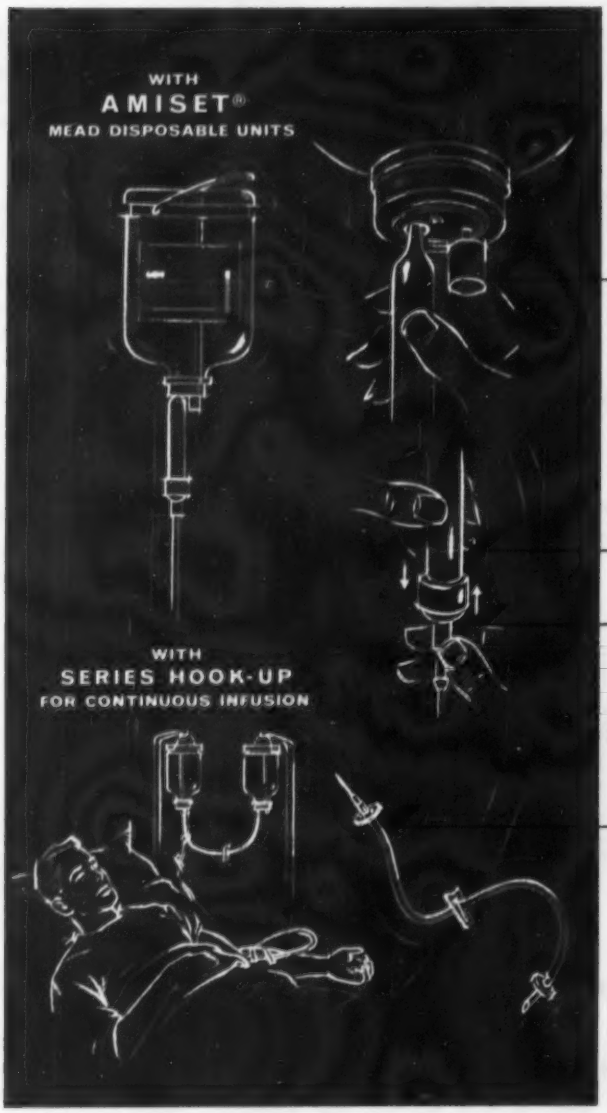

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the federal government. They hope to prove that good hospital service by charitable or local community groups is impossible of accomplishment. Second, those who wish to destroy all activities or organizations that aid the welfare and well-being of the people. The hospital stands high in this category and so it is their favorite target. "Socialized medicine is the keystone of the Communist arch," said Lenin, and this is still their guiding policy. Third, the lunatic fringe that seeks personal prominence, publicity and gratification by broadcasting derogatory rumors about what goes on in our hospitals.

15. Should the auditor talk with staff members, administrator and members of the governing board about hospital affairs?

Much valuable information about friction, public relations and the morale of workers can be gained in this way. Experience teaches that the auditor should be a listener rather than a talker. He should anticipate that anything he says, and much that he does not say, will be twisted in such a way as to discredit the audit and the auditor.

The aims, ideals and attitudes of those who come to talk with him are frequently clearly revealed, and all of these affect the quality of patient care.

16. What authority has the independent auditor to make changes in the hospital staff, administration or privileges?

He has no authority whatever. His function is to search for deficiencies and, if any are found, point out ways in which they may be corrected. He does not tell the hospital group that it must do this or that. He does tell it how other good hospitals of the same size and type are solving similar problems. He quickly learns that hospitals of similar size and type have much the same problems, wherever they may be located.

Hospitals that have employed an auditor with the expectation that he would rid them of obnoxious members have been disappointed. Power to correct deficiencies in the professional field lies with the local hospital group. But if one's faults lie in the field of ethics, the remedy lies with the medical society.

No outsider can correct anything. The desire for better professional standards, and the authority to produce them, must come from the hospital group itself.

CHEMORECEPTORS

A NUMBER of reflexes exist which may cause profound changes in blood pressure, heart rate, and respiration. These reflexes are mediated through the chemical excitation of sensory receptors. Of these reflexes only two are known to be elicited by fluctuations in the normal chemical environment of their receptors. These are the chemoreflexes of the carotid and aortic bodies. Changes in the normal chemical environment may excite receptors of the coronary chemoreflex, the pulmonary depressor chemoreflex, the pulmonary respiratory chemoreflex, or the stretch receptors of the carotid sinus and the Hering-Breuer reflexes, but this is not as yet proved. (The latter two are stimulated by chemicals as well as by mechanical stimuli.)

CAROTID CHEMOREFLEX (CAROTID BODY REFLEX)

The carotid body is described as being grossly visible as a reddish nodule firmly attached to the medial surface of a very small blood vessel which arises either from the occipital artery near its origin from the external carotid, or from the carotid itself. It is richly supplied with blood vessels and is surrounded by a network of nerves forming the carotid nerves (nerves of Hering) which join the glossopharyngeal nerves (Cranial IX) and enter the medulla oblongata. Experimental methods have shown that stimulating the carotid chemoreceptors, *i.e.* increasing their activity, leads to increased activity of the respiratory and vasomotor centers. The first visible result of this increased activity is a reflex peripheral vasoconstriction accompanied by increased respiratory movements (hyperpnea).

Reflexes mediated by the carotid body act as an emergency mechanism rather than an essential part of the animal's normal regulating system. The carotid body receptors are more resistant than cells of the respiratory center to depression by narcotics, anoxia and excessive carbon dioxide tension. It is therefore considered the *ultimum moriens* of the respiratory regulating system.

The normal chemical stimulus to increase the activity of the carotid body is either a reduction in pO_2 or an increase in the pCO_2 content of the fluid perfusing it. However, the reflex hyperpnea is consistently greater with anoxia (low pO_2) than with hypercapnia (high pCO_2). The pharmacological stimuli of the carotid body include many agents. These are sodium cyanide, nicotine, lobeline, piperidine, phenyldiguanide, acetylcholine, sulfides, adenosine triphosphate, veratridine, dinitrophenol, potassium, papaverine, sodium citrate and sparteine.

CAROTID SINUS PRESSOR RECEPTORS

Contrary to the original belief, it has been found that the pressoreceptors of the carotid sinus region are sensitive not only to mechanical stimuli but also to certain chemical substances. Chemical stimulation is manifested by a vasodepressor response and by a partial or complete blockade of the carotid sinus pressor reflex. Substances which have been found to excite this reflex include most veratrum alkaloids and andromedotoxin.

Experimental bilateral vagotomy eliminates the possibility that the fall in blood pressure is due entirely to the stimulation of thoracic receptors. Cutting the vagi also proves that the motor pathway for the chemoreflex of the carotid sinus is extravagal. The possibility that the action of the stimulant agents is on the carotid body has been eliminated by careful denervation of the carotid sinus while the carotid body innervation is left intact. The possibility that carotid sinus activity has been depressed centrally by these substances has also been eliminated. Injection of small amounts of the compounds into the wall of the carotid sinus has shown that the receptors lie somewhere within this wall.

AORTIC CHEMOREFLEX (AORTIC BODY REFLEX)

The aortic body lies in a relatively inaccessible region between the ascending aorta and the pulmonary artery. Serial sections have shown that, like the carotid body, the aortic body is composed of cords of rounded epithelioid receptor cells separated from the blood stream only by a thin wall of sinusoidal capillaries. The aortic body is also richly supplied with nerve fibers. The afferent nerve fibers from the aortic body enter the aortic or cardiac branches of the vagi with the recurrent laryngeal nerves or slightly higher. In the rabbit they seem to run entirely in the vagus trunks. It has been found that electrical stimulation of these afferent fibers elicits effects exactly like those produced by chemical excitants, *i.e.* hyperpnea and hypertension. In other words, stimulation from these chemoreceptors is due to a positive stimulant effect by nerve impulses upon the vasomotor and respiratory centers and not, as in the case of the pressoreceptors, to a removal of an inhibitory influence. This is true of the carotid body also.

Not unlike the carotid body the aortic body is excited by decreased arterial pO_2 and increased pCO_2 as well as by hemorrhage. (It is presumed that hemorrhage excites by intense constriction of arterioles sup-

plying the aortic body, so that as blood flow is reduced drastically, tissue pO_2 falls and metabolites accumulate.) Some of the pharmacological stimuli which excite the aortic body include sodium cyanide, nicotine, lobeline, piperidine, phenyldiguanide and acetylcholine.

CHEMORECEPTORS OF HEART AND LUNG

Since 1867 when Von Bezold and Hirt first showed that the intravenous injection of veratrine, a mixture of veratrum alkaloids, causes a very large fall in blood pressure and bradycardia, and respiratory apnea in animals, there has been progressive clarification as to the mechanisms by which these phenomena occur. At the same time the terminology used to describe this triad of reactions has become more confusing. The terms "Bezold effect," "Bezold-Jarisch effect," "Bezold reflex," and so on, were originally used to describe the reflex component of the depressor action of veratrum alkaloids which is due to excitation of sensory nerve endings within the heart; they did not refer to the respiratory apnea. Since 1949, however, these terms have at times been used to describe the triad of (1) sudden hypotension, (2) bradycardia and (3) apnea, which is observed on intravenous injection of many drugs, all of which effects are abolished by cutting the vagi. This careless use of terminology can only lead to confusion. It is for this reason that Dawes and Comroe (1954) proposed the following terminology: (1) *Coronary chemoreflex* to describe the reflex fall of blood pressure and heart rate which results from injection of substances into the coronary circulation (Bezold effect or Bezold-Jarisch effect). (2) *Pulmonary depressor chemoreflex* to describe the apnea which results from injection of substances into the pulmonary blood supply. It is this terminology which will be used in this paper to describe the triad of responses.

CORONARY CHEMOREFLEX

Evidence for the existence of a coronary chemoreflex has been drawn from a number of detailed experiments, *e.g.* localized injections in various parts of the heart of substances which elicit this reflex and progressive sectioning of nerves to the heart. There is no precise knowledge as to the location of the sensory receptors within the heart but it is believed that in the dog some, at least, exist in the left ventricle. In the cat, it is possible that the receptors for the coronary chemoreflex could be identical with atrial stretch receptors; however, there is still need for more precise proof. Thus far, the evidence available does not permit us to believe we are dealing with known sensory receptors and, until we do have proof of this, we must assume that the receptors for the coronary chemoreflex are as yet unidentified.

Progressive sectioning of the left vagal branches to the heart show that the afferent nerve fibers for the coronary chemoreflex come from the region of the left atrium beneath the left pulmonary artery and join the left recurrent laryngeal branch of the vagus as it passes over the aortic arch. The delineation of the afferent pathway on the right side is not as simple.

Dawes and Comroe (1954) have suggested that, since there are several ways in which a chemical substance, injected intravenously, can cause a fall of blood pressure and bradycardia which is abolished by cutting the vagi, it is essential to adapt a rigid definition of the coronary chemoreflex. A chemical compound should satisfy the following criteria before being included in a list of those substances which stimulate the coronary chemoreflex: (1) It should cause a fall of blood pressure and heart rate which is abolished by cutting the vagi; (2) this response is produced by injection directly into the coronary arteries of a dose at most one-tenth of that which causes the same effect on injection into the cavity of the left ventricles; (3) the latency between injection into the coronary vessels and the beginning of the cardiovascular response is short (2-3 sec.). Substances which fulfill these criteria in dogs are veratrine and most of the veratrum alkaloids and nicotine. In cats the list includes veratrum alkaloids, adenosine triphosphate, serum, various amidines, and 5-hydroxytryptamine.

PULMONARY DEPRESSOR CHEMOREFLEX

Injections into the right side of the heart and into the pulmonary circulation of substances which excite the pulmonary depressor chemoreflex have been valuable in localizing the receptors for this reflex in the lungs. Since many of the substances which stimulate this reflex also are active

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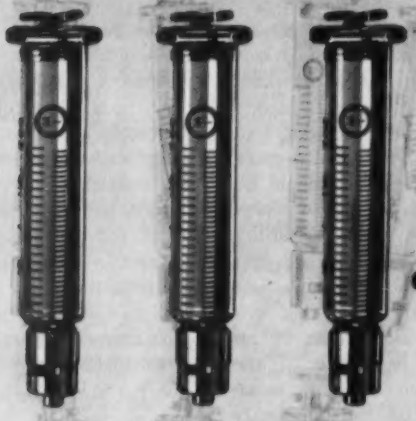

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in the coronary chemoreflex, care had to be taken to separate these two actions. Pulmonary and left ventricular circulation time were important in this respect. The response of this reflex is blocked by cutting the vagi, but there is still no adequate evidence for the origin of the afferent fibers involved. Here again, there is no precise evidence as to the location of the sensory receptors within the lungs. There is direct evidence that they are not identical with the aortic or atrial pressure receptors. There are in the lungs receptors which can be excited by mechanical changes. Their excitation produces a fall of blood pressure and heart rate which is abolished by cutting the vagi. It is possible that chemical agents can also activate these receptors.

Dawes and Comroe (1954) again deemed it desirable to have a set of criteria which substances should fulfill in order to be included in a list of compounds which stimulate this reflex. These criteria are: (1) It should cause a fall of blood pressure and heart rate which is abolished or greatly reduced by cutting the vagi; (2) this depressor effect should be substantially greater on injection into the right side of the heart than on injection into the left side; (3) with inhaled gases or aerosols special technics should be required to establish the site of action since there is always the possibility that the substances are absorbed into the blood stream and may be acting elsewhere; (4) the latency between injection into the right heart or inhalation and the beginning of the cardiovascular response should be short, not much more than the pulmonary circulation time. Substances which fulfill these criteria in dogs are veratridine, ethylacetoacetate and ethylproprionate. In cats the list includes bromine, serum, amidines, 5-hydroxytryptamine and veratrine.

HERING-BREUER REFLEXES

It is necessary to include these reflexes at this point in order to distinguish them from the pulmonary respiratory chemoreflex which follows.

The receptors for the Hering-Breuer inflation reflex are slowly adapting stretch receptors which Widdicombe has localized in the bronchial walls. The afferent pathway is via the vagi. These stretch receptors are stimulated when the lungs are distended with a resultant slowing or temporary arrest of breathing. Contrary to original ideas, these stretch receptors can be excited or paralyzed by certain chemical substances either by injection or inhalation. Injections of veratrine and Veriloid (R) and possibly the inhalation of veratridine have been shown to excite these slowly adapting stretch receptors and result in apnea or slowing of respiration, with reduction in depth. This phenomenon has been shown to be distinct from the coronary chemoreflex by the fact that it appears after injection of drugs into the cavity of the right ventricle or into the pulmonary artery, but not after injection into the left atrium or ventricle or into the left coronary artery. Inhalation of gaseous anesthetics, such as trichlorethylene, results in rapid shallow breathing owing to an action on these same stretch receptors. This is, however, a sensitizing rather than a stimulating action. There is an additional group of stimuli which cause paralysis of the receptors which results in slow, deep breathing or prolonged inspiration. This group includes inhalation of steam, injection of local anesthetics, and high concentrations of gaseous anesthetics.

There is a possibility that there are chemicals which act on the sensory receptors for the deflation component of the Hering-Breuer reflex, but until the nature of the afferent vagal nerve fibers for these receptors has been identified, this must remain a matter of speculation.

PULMONARY RESPIRATORY CHEMOREFLEX

It has been shown that a large number of amidine derivatives cause a temporary arrest of breathing in the position of expiration followed by a period of rapid shallow respiration. That the receptors stimulated by these substances and causing this phenomenon are different from any of the receptors heretofore discussed is fairly certain. They are not identical with the slowly adapting stretch receptors. This conclusion is supported by evidence obtained from: (1) direct records from single vagal afferent nerve fibers; (2) the variation in the temperature at which the response from the two receptors is blocked when the vagi are cooled, and (3) the difference in the characteristics of the response to stimulation of the two receptors. (There is a respiratory pause followed by a period of rapid respiratory movements in the case of

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Precisely regulated temperature, humidity and oxygen—"The Chapple incubator and isolation unit (The Isolette) provides temperature, humidity and oxygen control and filtered outside air within a chamber which is kept constantly closed."[2] "This incubator . . . has many advantages . . . visibility, the maintenance of a constant temperature and high humidity and the ease of caring for the baby without disturbing it or altering the environmental conditions greatly . . ."[3]

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Useful as an isolation unit—"Individual air-conditioned incubators in which strict isolation is maintained at all times may be utilized for either the nonsuspect or the suspect infants . . . It may even be possible to omit an isolation nursery . . ."[6]

Protection from cross-infection by forced air circulation—". . . individual isolation provided by Chapple's bed protected the baby from dangers of cross-infection . . . the infant is surrounded by conditioned fresh air drawn directly from outdoors and is further protected from all droplet infection . . . We now have four of the old-type Chapple beds and eight of the new-type 'Isolettes' and have at last achieved the ideal for which we aimed."[7]

High humidities without temperature variation—"In the forced air circulation type of incubator . . . it is possible to raise the humidity as high as 95% without varying the temperature within the incubator."[8]

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"Such incubators are expensive but certainly no more so than many another piece of hospital equipment that contributes to the saving of lives."[1]

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1. Lull, C. B., and Kimbrough, R. A.: Clinical Obstetrics, Philadelphia, J. B. Lippincott Company, 1953, pp. 633, 634.
2. Hess, J. H., and Lundeen, Evelyn C.: The Premature Infant, ed. 2, Philadelphia, J. B. Lippincott Company, 1949, p. 43.
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8. Danelz, J., and Cardullo, H. M.: Incubator care of the premature infant, Pediatrics 6:432, 1950.

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the pulmonary respiratory chemoreflex while the rate of breathing increases slowly toward the initial frequency in the case of the stretch receptors.) It seems unlikely that the receptors for this response are the same as those in the lungs which are responsible for the fall of blood pressure and heart rate even though they are stimulated by some of the same substances. However, the evidence for this belief is not conclusive. Direct records also show that these receptors are not the same as atrial receptors or aortic pressure receptors. There is no evidence to suggest that they are the same as the chemoreceptors of the carotid or aortic bodies.

All of the foregoing work was done in the cat. Some of the substances which cause apnea in the cat cause stimulation of respiratory movements in dogs by exciting the chemoreceptors of the aortic and carotid bodies. As yet, there is no direct evidence for similar pulmonary respiratory receptors in the lungs of dogs, but there is a good deal of evidence which points in this direction. It is believed that these receptors in dogs can be excited by some antihistamine drugs.

The criteria given by Dawes and Comroe for this reflex are: (1) The substance should cause a transient arrest of breathing, which is abolished by vagotomy. (2) Apnea should be observed only on inhalation or on injection into the pulmonary circulation; if the drug has other sites of action as well, the pulmonary site of action must be established by other procedures. That the apnea is due to an action on receptors in the lungs will receive substantial support if the latent period between injection or inhalation and response is on the average 2 seconds or less. (3) The pattern of the respiratory response should be closely similar to that caused by amidines in the cat. The response may be different or absent in other species. (4) The respiratory response should not be abolished until the temperature of the vagi is reduced to from 2° to 4° C. in the cat. This is a simple method of establishing that the effect is not like that of veratridine upon slowly adapting pulmonary stretch receptors, which is blocked at about 10° C. It is nevertheless desirable that the effect of the substance should also be tested on single fiber preparations of pulmonary stretch receptors to exclude the possibility that it alters their excitabilities as well. The few substances which have met these criteria are phenyldiguanide, 2-alphanaphthyl ethyl isothiourea, diphenhydramine, nepyramine, ammonia (injected) and possibly 5-hydroxytryptamine.

SUMMARY

It has been known since the work of Loevenhart, Heymans, Schmidt, Gesell and Soma Weiss that the stimulation of the chemoreceptors of the carotid sinus by either cyanide or alpha lobeline could be used as a test of the arm to carotid artery circulation time. For this purpose, alpha lobeline is usually used in a dose of 1 mgm. intravenously. The end point is clear in that stimulation of the chemoreceptors produces rapid deep respiration. The Bezold chemoreflex has not as yet been carefully studied in man and most of the work is based entirely on work done in experimental animals. It is possible that if similar reflexes are found to exist in man, some of the transfusion and other hypotensive reactions which occur after intravenous injection may be more logically explained. — MARJORIE E. PERKINS, A.B.

Photographs, courtesy of The Edith Hartwell Clinic of The Strong Memorial Hospital, Le Roy, N. Y.

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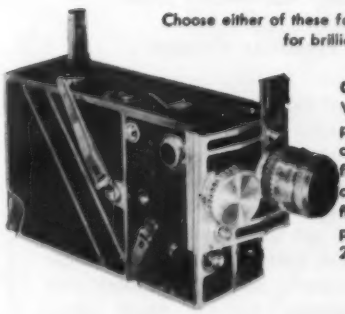

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Good Training Makes Good Cooks

Outline of the course given to cooks at the New York State school for food service employes

CYNTHIA BISHOP

Associate Director of Nutrition, Hudson River State Hospital, Poughkeepsie, N.Y.

IN 1948, the New York State Department of Mental Hygiene established the Food Service Training School at Hudson River State Hospital, Poughkeepsie, N.Y., as one method of improving the food service program in its state institutions. The objectives of the course and the organization of the school were described in the first section of this article, which appeared in the February issue of The MODERN HOSPITAL.*

As explained in that article, the objectives are as follows:

1. To develop higher standards of food preparation and service in the department's institutions.

2. To develop efficiency in the use of food supplied, with emphasis on the principles of good nutrition in all phases of menu planning.

3. To employ preventive measures against food-borne diseases through food sanitation.

4. To create maximum efficiency and safety in kitchen operations through the proper use of equipment.

The outline of the course by means of which these aims are achieved is presented in this second, and concluding, section of the article.

OUTLINE OF PROGRAM FOR COOKS

The division of work is as follows:

1. First week. This week consists of a combination of classroom and demonstration work on new and standard procedures in all phases of food operation.

2. Second week. This week is spent in the laboratory preparing foods, using the formulas, and assisting in testing new formulas.

3. Third week. The group is divided, each section working in one of the hospital's large kitchens, supervised by a member of the school staff and the head cook of the kitchen.

Training material has been assembled and is available to the students. Each one is given a notebook containing work sheets in outline form, which they are required to fill in during the lectures and discussions. These serve several purposes: They assure that the correct information is being noted; they provide simpler means of study for those who have not been in school for many years, and they give the student a permanent record which he can take home with him and use as a reference. Besides these notebooks, the school has charts, films and a library of books and magazines pertaining to all forms of food service.

The students are graded on their work. Tests are given each morning of the first week, based on the previous day's work. An average is taken of the results of these tests. A final examination is given on the last day. The average of the tests plus the final examination is the grade used. Because of the great diversity in the educational background of the students, an average of 65 per cent has been set as the passing grade. The laboratory and kitchen work are graded by the individual instructors and the two head cooks working with the school. The civil service rating is used to determine these grades. The average must be 75 per cent. The student must pass both the theory and practical work to earn a certificate.

The first day in class, the students learn to make coffee. They learn about the correct grind, the proper proportion of coffee to water, the use of fresh, cold water, and the amounts to make so that it can be served immediately and not have to be reheated. The care of the coffee urns is included in this instruction. The students take turns making coffee each morning for the first two weeks so that all have the experience. They enjoy drinking it at their midmorning recess.

STRESS PERSONAL HYGIENE

In mass feeding, personal hygiene is one of the most important subjects. The student learns certain rules and regulations that must be followed, as well as good habits to practice and bad ones to avoid 24 hours a day. Stressed are the importance of wearing clean uniforms, hair nets for the women cooks, and caps for both men and women, keeping hands clean, nails short and scrubbed, daily baths, and no smoking in food areas. Since the improper use of hands is of utmost importance to the health and well-being of everyone, the students are taught:

1. Not to taste food with their fingers.

2. Not to scratch their heads or blemishes.

3. Not to wipe their hands on their clothes, but to use paper towels.

Improper use of tables and counters

* Bishop, Cynthia: Better Food for Mental Patients. Mod Hosp. 84:110 (February) 1955.

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A stagger system is employed in the preparation of the food sent to the patients' cafeterias. While food carts are being loaded, one at a time, additional food is being prepared throughout the entire loading period.

is also discussed. They are told that:

1. They should not sit on tables or counters where food may be placed.
2. They should not place feet on lower shelves where dirt and contamination from shoes could come in contact with food and utensils.
3. Personal effects should not be placed under counters or in table drawers used for cutlery, or in any equipment. They should be left in lockers.

The danger of anyone with colds, sores and boils working is stressed and the students are cautioned against sneezing or coughing over food.

At the end of this lecture, the students are advised that these rules are strictly enforced at the school and that part of their grades will be based on the manner and care with which they are carried out.

Cleanliness in the food area is a "must" and housekeeping is one phase of the food service from which no one is ever graduated. It need not be a drudgery, inasmuch as a little planning and forethought can make it a routine which is just as much a part of the job as cooking. The discussion on the housekeeping duties includes the care of floors, windows, hoods, refrigerators, storage rooms, restrooms, tables, garbage cans, all kitchen equipment, and the general cleaning tools, *i.e.* mops, brushes and so on. In planning the routine for the kitchens, the cooks are advised to have a regular cleaning schedule, one for tasks that need to be done daily and one for those needing to be done weekly or monthly. Scheduling divides the work more evenly, ensures its being done, and develops teamwork. Cooks are cautioned that their kitchen should be ready for inspection at any hour.

Even though most of the cooks are not responsible for dishwashing, a lesson on this subject is included as the principles apply to pot and pan washing for which they are responsible, and proper cleansing of all eating and preparation utensils is one of the most important jobs in the food service departments. When done properly it helps considerably in the prevention of the spread of diseases, outbreaks of diarrhea, and so-called food poisoning.

The department of mental hygiene together with the New York State Department of Health promulgated standards for all types of dishwashing and pot and pan washing in the institutions, and these are reviewed in detail with the students. They are taken through the steps of proper scraping, prerinsing or prewashing, correct racking of dishes, timing of the washing at 140°F. and the rinsing at 180°F., and the air drying of the eating utensils. Included in this discussion is the importance of the correct ratio of detergent to water and the cleanliness of the machines. Proper handling of the clean utensils to prevent recontamination is stressed and the students are shown that they have a responsibility to teach the patient employes to follow through on good handling and storage. When not in use the clean dishes should be placed in closed storage with the glasses, cups and bowls inverted and the silver stored in upright containers with handles extending beyond the container to eliminate the chance of contamination. The institutions use a variety of dishes—plastic, china and metal. Since all of them stain somewhat, methods of removing these stains are reviewed. Movies are used as a visual aid in teaching the dishwashing lesson.

As the cooks are responsible for pot and pan washing, this procedure is reviewed in detail as follows:

1. Scraping and prewashing.
2. Washing in clean water containing the proper amount of detergent at 110°F.
3. Scrubbing with a brush or metal sponge if necessary. Steel wool is never used because of the possibility of pieces of it being left in the pan and getting in food and also because of the accident hazard it presents.
4. Sterilizing in water of 180°F.—steam coils in the sink help to keep this temperature.
5. Air drying.
6. Storage of the pots and pans to allow free circulation of air in clean cabinets or on shelves; nothing stored while wet or on the floor.

In the discussion about personal hygiene, the importance of absolute cleanliness was emphasized in regard to equipment, utensils and person. In order to understand the underlying principles behind these rules, it is necessary to know why such strict care in sanitation is necessary. What is it that causes outbreaks of disease in institutions? Why is it that when one has a cold others succumb also? In all cases, certain preventive measures must be taken, but particularly so in those kitchens where large quantities of food are prepared. To protect the food department and to assist in tracing the cause of any out-

break, the kitchens in all department institutions are required to keep samples of all foods prepared. These are kept for 24 hours in specially built cabinets in a refrigerator in each kitchen.

To help the students understand these principles, a sanitarian from the state health department discusses them and the laboratory personnel of the hospital gives a demonstration in which sterile agar plates are contaminated by the students. One touches a plate with his fingers, then the hands are washed with soap and water and he touches another plate with his clean fingers; one coughs on a plate; one takes a hair from his head and places it on a plate; dust is taken from the window case with a dust cloth and put on a plate. These plates are incubated for 48 hours in the pathology laboratory and then shown to the students. The demonstration has proved to be a real eye opener and has encouraged good sanitation practices.

LECTURES ON SAFETY

Since one-third of the state employes are in the department of mental hygiene, the percentages of accidents could be quite high. To control the incidence of accidents, the department has a safety consultant and each hospital has a safety engineer on its staff. The safety consultant talks to each class and covers all phases of the operations in the kitchens: use of gas and electric equipment, handling of cutlery, use of power equipment, care of floors, lifting of heavy objects, proper labeling of supplies, and even the type of clothes and shoes the employes wear. The chief of the fire department at the hospital gives a demonstration of the different kinds of fire extinguishers and shows how and when they should be used. As a result of these lectures, the number of accidents in the kitchens has been cut down.

Because two of the most important phases in the control of food are the care taken when it is received and stored, these factors are discussed with the students. All the food for the state institutions, other than that which they grow, is purchased according to specifications by the New York State Division of Standards and Purchase and is received at the institutions in a central storeroom from which it is distributed to the kitchens. It is the responsibility of the charge cook to sign for the deliveries to his kitchen and when he signs he is saying, in effect, that he has received the amount called for in good condition. This is important because if he does not have the correct amount he will not be able to follow the formulas. Along with the lectures on these points, demonstrations are given on receiving food in the laboratory.

METHODS OF FOOD STORAGE

The storage of all food is of vital importance and the proper procedures to avoid surplus food wastes and loss of important food values are reviewed. These include:

1. Meat. Stored at 32 to 38°F. in shallow pans and covered. Frozen meat at 0°F. and a timetable for thawing the meat in refrigerators at 32 to 38°F. is given. Frozen fish at 0°F. and thawed at 32 to 38°F.

2. Fruit and Vegetables. Stored at 40 to 50°F. on racks to allow air circulation, cleaned before storing, and stacked to allow use of old stock first.

3. Dairy Products. Stored at 32 to 38°F. in separate refrigerators, covered and stored to allow air circulation.

4. Dry Storage. Stored at 50 to 60°F. in a well ventilated room on open shelves and floor racks placed to allow for air circulation, easy cleaning, and easy inventorying. Foods needing refrigeration, such as brown sugar, corn meal, soy flour and grits, are listed.

All the institutions are required to keep charts showing refrigeration temperatures, taken twice daily from every refrigerator in the kitchens. Sometimes this is the responsibility of the institution engineers, but usually the charts are kept by the cooks so the importance of this procedure is discussed at the school.

Simple nutrition is presented in combination with directions for proper food preparation after an elementary review of what nutrition is, why we eat, and how food is used in the body.

A discussion of protein and its growth and repair functions is correlated with the discussion of the preparation of meat, eggs, milk and cheese and the effects of heat on these foods is shown by demonstration. The advantages of low temperature meat cooking are determined by the students themselves after participating in a comparative test where beef roasts of equal size and weight are cooked —one started at 450°F., then covered and roasted, the other roasted uncovered in an oven heated to 325°F. and both cooked until an internal temperature of 140°F. is reached.

Carbohydrates and fats and their functions of producing heat and energy are correlated with the preparation of potatoes, paste products, desserts, and with the use of oils. The changes heat produces in starch are shown as are the undesirable changes high heat has on fats.

The students are given charts on vitamins and minerals and their sources and functions are reviewed with them. The preparation of fruits and vegetables is correlated with this discussion and emphasis is placed on the effects of cooking, particularly on the water-soluble vitamins. They are taught to cook vegetables in very little water for a short time and to make more use of the pressure steamers to preserve food values. Staggered cooking of small batches is stressed as is the importance of saving all liquids from vegetable cookery for use in sauces and soups. In this lesson, salads are discussed and the students are told that salads should be prepared at the last minute, especially cabbage salad, to preserve the vitamin content of the vegetables.

During the discussion on food preparation, the efficient use and care of equipment is stressed. In conjunction with this, the use of proper utensils for baking and cooking operations is presented, with attention to the value of different metals.

TAUGHT TO SCHEDULE WORK

Work schedules are also considered. At the beginning of the week, each student is given a theoretical problem using a specific menu. The number of employes to handle the preparation of this menu, the equipment available, hours of meal service, and the number to be served are stated. The student is asked to make a work plan to meet this situation. His solution to the problem is reviewed and filed until the end of the week, at which time he is given a similar problem and again asked to complete a work schedule. In this way, the instructor is able to judge how effective his teaching has been.

The second week the students spend in the laboratory and practice the principles learned in the classroom. They are instructed in the use of all measuring and weighing devices and use them in the preparation of

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all the formulas. Some of the formulas are those that are in the testing stages and they are made in small amounts. Arrangements are made with the kitchen employes in the building in which the laboratory is located for preparation of some of their food so that the students have the experience of the large quantity cooking. They employ a stagger system in the preparation of food sent to the patients' cafeterias in the building.

Enough of each food prepared is kept for the students' own lunch. It is served cafeteria style and they eat at the large table in the classroom. The staff of the school eats with them and there are usually invited guests from the hospital staff. Inviting different people to lunch each day was started as a public relations measure and has given the guests, who have included doctors, nurses, department heads, supervising office personnel, and even the director of the hospital, a better understanding of what the food service department is doing.

Immediately after lunch, there is a discussion of the food that has been served. Each student reviews the procedure used in preparing his menu item and gives his opinion of the final product; then the other students tell what they think of it. Some of the points that are considered in the discussion are:

1. Does the food have eye appeal?
2. Is the flavor acceptable?
3. Is this formula practical for your institution?
4. Is this food suitable for service to mental patients?
5. Did you make efficient use of equipment?
6. Did you plan your work efficiently?
7. Were the raw food losses out of line in the preparation?
8. In your institution, could you prepare this type of meal with the amount of help and the equipment you have available?
9. Did the combination of foods served make a balanced meal?
10. If not, what was missing?

After the discussion, the students clean the kitchen and do the dishes. The latter are done in a three-compartment sink with steam coils in the third compartment for sterilizing at 180° F. After being air dried, they are stored in closed cupboards in the kitchen. When the kitchen is spick and span, the students return to the classroom and the assignments for the next day are given out. At this time they can ask questions regarding any procedures about which they may have doubts.

The third week is spent in two of the large hospital kitchens, half of the group going to each kitchen where they prepare food under the supervision of the head cooks of these two kitchens. The assignments are made to each student by one of the staff of the school. A copy of the assignments for hospital menu preparation is given to each head cook and there are daily consultations concerning them. The head cooks supervise and instruct the students in planning the work procedure according to the formulas to be used and in the actual preparation of the food.

The students have the opportunity of seeing the food processed from receipt to the table when the patient sits down to eat. They assist with checking in the food, storing it according to the principle they learned in the classroom, and issuing it for use in the daily menu.

After the preparation is completed,

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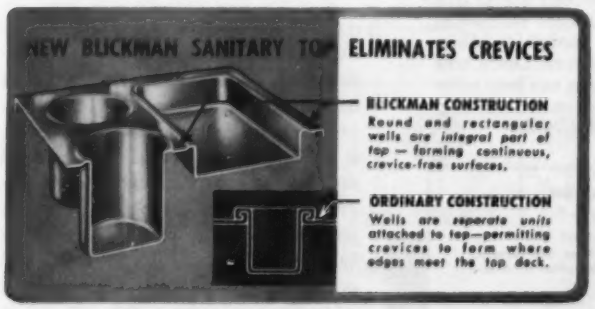

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the students are assigned each day to work on the counters in the patient cafeterias to assist in serving the food they prepared. This is done to complete the picture of the food preparation and service and it gives them the opportunity to see the patients' acceptance of the food.

The food service instructor works with the head cooks in evaluating the practical ability of the students. They are rated on:

1. Quality of product.
2. Knowledge of food standards.
3. Applied nutrition.
4. Knowledge of sanitation standards.
5. Sanitary practices.
6. Cost consciousness.
7. Yield of formula.
8. Organization ability.
9. Use of time.
10. Willingness to take responsibility.
11. Initiative, accuracy and judgment.
12. Ability to work with others.

On satisfactory completion of the course, a diploma is issued. It is signed by the commissioner of the department of mental hygiene, the director of nutritional service of the department, and the director of the Food Service Training School. It is sent to the director of the student's institution and at the next meeting of the food service committee, which is composed of the hospital's administrative assistant, the business officer, the dietitians, the food service manager, and representatives of the nursing and ward services, the director awards the diploma to the student. At the same time, the student is required to report on his training. In this way, the department's high standards are continuously kept before the employes of the institution.

It is felt that through this inservice training program some of the objectives of the nutrition division of the department of mental hygiene have been realized. Standards of food preparation have been raised; there is greater efficiency in the use of food supplies; improved sanitary conditions in food handling are evident, and greater safety in kitchen operations has been achieved by standardized procedures. The representatives from each institution who have shared in this program—686 to date—have also gained an appreciation of their own responsibility in the task of feeding patients.

Menus for April 1955

F. W. Anderson
Food Administrator
Lutheran Hospital
Brooklyn, N.Y.

1 Orange Juice French Toast, Sirup • Minted Fruit Cup Fried Filet of Sole Tartare Sauce Whipped Potatoes Grilled Tomato Lettuce Salad Lemon Meringue Pie • Cream of Pea Soup Codfish Cakes With Spaghetti Wax Beans Tossed Green Salad Raspberry Gelatin With Whipped Cream	**2** Sliced Banana Bacon, Raisin Toast • Cream of Corn Soup Ham and Rice Patty Potato Pancakes Whole Leaf Spinach Tomato-Lettuce Salad Spice Cake With Chocolate Frosting • Grape Punch Chicken Chow Mein Fluffy Rice Crisp Noodles Brussels Sprouts Asparagus Salad Almond Bavarian Cream	**3** Pear Nectar Sausages, Nut Roll • Consommé With Rice Southern Fried Chicken Mashed Potatoes Green Peas Stuffed Celery Ice Cream, Cookies • Apricot Nectar Chopped Sirloin Home Fried Potatoes Tomato Stuffed With Cottage Cheese, Chives Elberta Peach	**4** Fruit Compote Shirred Egg, Sweet Bun • Cream Cheese Canapés Roast Leg of Lamb Mint Jelly Browned Potatoes Mixed Vegetables Heart of Lettuce With Russian Dressing Apricots • Pineapple Juice Braised Liver O'Brien Potatoes Buttered Asparagus Mixed Green Salad Strawberry Whip	**5** Stewed Prunes French Toast, Sirup • Vegetable Cocktail Ravioli, Meat Sauce Parslied Potatoes Whole Carrots Romaine, Vinaigrette Cherry Pie • Beef Noodle Soup Ham and Eggs Country Style Home Fried Potaoes Harvard Beets Tossed Green Salad Mayonnaise Fruit Cocktail	**6** Pineapple Juice Soft Cooked Egg, Roll • Pineapple Mint Cup Roast Veal, Gravy Lyonnaise Potatoes Buttered Broccoli Tomato-Cucumber Salad Apricots • Consommé With Rice Meat Loaf, Mushroom Sauce Mashed Potatoes Green Lima Beans Heart of Lettuce With Russian Dressing Apple Pie With Cheese
7 Grapefruit Sections Sunnyside Egg, Toast • Relish Plate Chicken Pot Pie Parslied Potatoes Buttered Beets Coleslaw Pineapple • Creamed Vegetable Soup Lamb Patty Baked Potato Mixed Vegetable Tomato Salad With Mayonnaise Cup Custard	**8** Orange Juice French Toast, Sirup • Tomato Juice Baked Cod Steak With Egg Sauce Whipped Potatoes Green Beans Heart of Lettuce Salad Tapioca Pudding • Split Pea Soup Tuna Club Sandwich Tossed Green Salad With French Dressing Pickles and Olives Lemon Iced Cake	**9** Sliced Banana Scrambled Eggs, Roll • Fruit Cup Old Fashioned Lamb Stew Buttered Asparagus Tossed Salad with French Dressing Purple Plums • Cream of Mushroom Soup Barbecued Beef on Bun Green Peas Tomato-Cucumber Salad Bread Pudding With Fruit Sauce	**10** Apricot Nectar Bacon, Cinnamon Toast • Pineapple Juice Baked Virginia Ham Spiced Crab Apple Glazed Sweet Potatoes Green Peas Celery and Olives Ice Cream, Cookies • Chicken Noodle Soup Cold Cuts Tomato and Asparagus Salad Parker House Rolls Elberta Peaches	**11** Pineapple Juice Pancakes, Sirup • Citrus Fruit Cup Smothered Chicken Parslied Potatoes Wax Beans Tomato Salad Blueberry Pie • Cream of Potato Soup Hamburger on Bun Ketchup, Pickle Relish French Fried Potatoes Baked Apple	**12** Pear Nectar Sausage, Raisin Toast • Stuffed Celery Veal Cutlet, Mushroom Sauce Whipped Potatoes Buttered Carrots Tossed Green Salad Strawberry Shortcake • Apricot Nectar Macaroni au Gratin Buttered Asparagus Coleslaw Gingerbread With Whipped Cream
13 Sliced Banana Bacon, Corn Muffins • Vegetable Soup Cheese Omelet Parslied Potatoes Julienne Green Beans Spring Salad Cherry Cheese Pie • Grape Juice Braised Tongue, Raisin Sauce Home Fried Potatoes Succotash Tomato Salad Peaches	**14** Blended Juice Scrambled Eggs, Toast • Breaded Pork Chops Applesauce Baked Potato Whole Leaf Spinach Coleslaw Celery and Olives Vanilla Ice Cream • Pineapple Juice Grilled Frankfurters Sauerkraut Boiled Potato Tossed Green Salad Bread Pudding	**15** Grapefruit Sections French Toast, Sirup • Grape Punch Broiled Halibut Steak, Lemon Wedge Whipped Potatoes Garden Peas Lettuce Wedge With 1000 Island Dressing Purple Plums • Vegetable Soup Tuna Corn Loaf French Fried Potatoes Grilled Tomato Mixed Green Salad Strawberry Whip	**16** Stewed Prunes Soft Cooked Egg, Roll • Minted Pineapple Cup Chicken Fricassee Dumplings Squash Tomato Salad Spice Cake With Applesauce Topping • Yankee Bean Soup Veal Chop Hunter Style Parslied Potatoes Brussels Sprouts Tossed Salad Assorted Gelatin Cubes With Whipped Cream	**17** Orange Sections Sunnyside Egg, Toast • Tomato Juice Roast Sirloin of Beef Oven Browned Potatoes Whole Carrots Romaine With French Dressing Ice Cream, Cookies • Cream of Asparagus Soup Chicken Chow Mein Steamed Rice Crisp Noodles Garden Peas Heart of Lettuce Salad Green Gage Plums	**18** Grapefruit Juice Sausage, Vienna Roll • Baked Veal Cutlet With Vegetable Sauce Whipped Potatoes Stuffed Celery Tossed Green Salad Kadota Figs • Consommé Baked Macaroni and Cheese Buttered Asparagus Coleslaw Gingerbread With Whipped Cream
19 Peach Nectar French Toast, Sirup • Beef Noodle Soup Grilled Sausages Brown Rice Buttered Broccoli Tomato Salad Cherry Pie • Apple Juice Lamb Stew in Casserole Mixed Vegetable Salad Pickles, Celery, Olives Fruit Cocktail	**20** Sliced Banana Poached Egg, Muffin • Tomato Juice Roast Leg of Lamb, Mint Jelly Browned Potatoes Whole Leaf Spinach Heart of Lettuce Salad Bartlett Pears • Tomato Bouillon Hot Roast Beef Sandwich Mashed Potatoes Whole Kernel Corn Romaine, French Dressing Almond Bavarian Cream	**21** Fruit Compote Soft Cooked Egg, Toast • Citrus Fruit Cup Smothered Chicken Whipped Potatoes Squash Pickled Beets Lemon Meringue Pie • Cream of Potato Soup Cheese Soufflé Marshmallow Fruit Salad Hot Biscuits Ginger Bread With Whipped Cream	**22** Grapefruit Sections Pancakes, Sirup • Fruit Punch Fried Filet of Sole, Tartare Sauce Parslied Potatoes Green Beans Tossed Salad Ice Cream, Cookies • Cream of Vegetable Soup Tuna Club Sandwich Deviled Egg Salad Lima Bean Casserole Gelatin, Whipped Cream	**23** Orange Juice Scrambled Eggs, Nut Roll • Minted Fruit Cup Individual Beef Pot Pie Duchesse Potatoes Wax Beans Tomato Salad Chocolate Iced Cake • Beef Noodle Soup Chicken Chow Mein Steamed Rice Crisp Noodles Green Peas Lettuce, Mayonnaise Baked Custard	**24** Pineapple Juice Grilled Ham, Muffin • Cream Cheese Canapés Southern Fried Chicken Whipped Potatoes Mexican Corn Celery and Olives Ice Cream, Cookies • Cherry Juice Lamb Patty Baked Potato Buttered Broccoli Tomato Salad Bing Cherries
25 Apricot Nectar Sausages, Raisin Toast • Fruit Cup Roast Loin of Pork Spiced Crab Apple Oven Browned Potato Red Cabbage Mixed Green Salad Kadota Figs • Chicken Noodle Soup Grilled Frankfurter French Fried Potatoes Green Beans Tossed Salad Bread Pudding With Whipped Cream	**26** Grapefruit Juice Bacon, Bran Muffins • Vegetable Cocktail Broiled Filet Mignon Stuffed Baked Potato Green Peas Lettuce, Russian Dressing Fruit Cocktail • French Onion Soup Ham and Eggs Country Style Home Fried Potatoes Chef's Salad Lemon Snow Pudding	**27** Pear Nectar Soft Cooked Egg, Toast • Citrus Fruit Cup Spanish Omelet Mashed Potatoes Buttered Asparagus Tomato Stuffed With Olives, Cottage Cheese Rice Pudding • Cream of Potato Soup Braised Tongue, Raisin Sauce Parslied Potatoes Buttered Beets Tossed Salad Spice Cake	**28** Grapefruit Section Grilled Ham, Roll • Stuffed Celery Individual Chicken Pie Duchesse Potatoes Whole Leaf Spinach Tomato-Cucumber Salad Pineapple-Cheese Pie • Chicken Noodle Soup Beef Patty Vegetable Plate Spring Salad Apple Brown Betty With Foamy Sauce	**29** Orange Juice French Toast, Jelly • Grapefruit Juice Broiled Salmon Steak Whipped Potatoes Green Peas Mixed Green Salad Strawberry Bavarian Cream • Grape Punch Salmon Croquettes Baked Potato Buttered Broccoli Heart of Lettuce With 1000 Island Dressing Purple Plums	**30** Fruit Compote Sausages, Bran Muffins • Minted Pineapple Cup Turkey Cutlet Potato Pancake Buttered Carrots Tomato Salad Baked Custard • Apricot Nectar Veal Chops Parslied Potatoes Buttered Squash Romaine, French Dressing Chocolate Cake

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Consultant and Executive Director
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Glen Oaks, N.Y.

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PERHAPS no single aspect of hospital organization has undergone as revolutionary a transformation in recent years as the communication and transportation systems between and within departments and services. Until fairly recently hospitals have, in comparison with business and industrial institutions, been slow in applying the fruits of scientific developments in these fields. Some of the older hospital plants are quite unequal to present communication and transportation needs. In the past, rapidity of communication, so essential today, was measured by the speed with which two legs could cover the length of a corridor. Nevertheless, during the last decade many of these older hospitals have installed electronic and mechanical systems to help speed up patient service and to knit departments more closely. As good as these systems are, their installation in buildings not specifically designed for their use cannot result in more than a fraction of their efficiency potential.

The lag between industrial and hospital planning is gradually disappearing. New hospitals are now designed from the ground up around their distinctive transport and communication services. The planning is a joint operation combining the skills of the architect, the hospital consultant, the communications engineer, and hundreds of specialists. To create an integrated and efficient transportation and communications system the administrative and intradepartmental and interdepartmental operating patterns must be worked out in advance during the planning stages. The potential loads each system must bear have to be established. The choice of equipment must be made and the quantities, locations and types must be predetermined. It becomes possible with such planning to create a truly functional plan which will meet all the communication and transportation needs of a highly efficient and well-integrated hospital. The future growth of the institution must be taken into consideration and provisions made for expansion of the initial communication and transport mediums. No doubt future advances in medical care will render such plans obsolescent over the years but a hospital so planned has a far better potential for efficient service and growth without excessive cost than was possible a few years ago.

With these planning methods the various communication and transportation systems incorporated in the Long Island Jewish Hospital were designed to relate every department and service within the hospital to one another; to relate the nurses and the patient, the department heads and their staffs. They promise a remarkable gain in administrative efficiency, patient service, and personnel economy. Basically, they were incorporated in the plan to permit highly trained employes to devote more of their time to the technics for which they were trained and less to services that were once considered unavoidable drudgery. In essence, by mechanizing these services, it is hoped to render a higher level of patient care at a reduced cost.

The wide range of communication and transportation facilities that were included in this plan are the following: batteries of dumb-waiters and elevators, pneumatic vacuum tubes, remote telephonic dictating equipment, direct dial telephone, conveyor belt systems, radio paging, electronic intercommunication, audio-visual call units, and electronic devices for patient supervision. Some of these are entirely novel in both design and use. Some have been modified and adapted from experience in other institutions and are fortunately now becoming standard equipment in every modern hospital. What is perhaps most unusual is the manner in which they have been coordinated and the daily routine planned around their use.

At the heart of the system that provides the hospital with complete and instantaneous articulation is an electronic interdepartmental call system. This system links every department and every facility in the hospital. In addition, similar systems are provided for the major subdivisions of all departments. The system provides for the director and the assistant director to make direct contact with all administrative departments, service units, clinical and laboratory divisions simply by depressing a button on the intercommunication master units in these executives' offices. Master units are located also in offices of all department heads.

Any master station in the system can originate a call to any other. To make the call, a button is depressed

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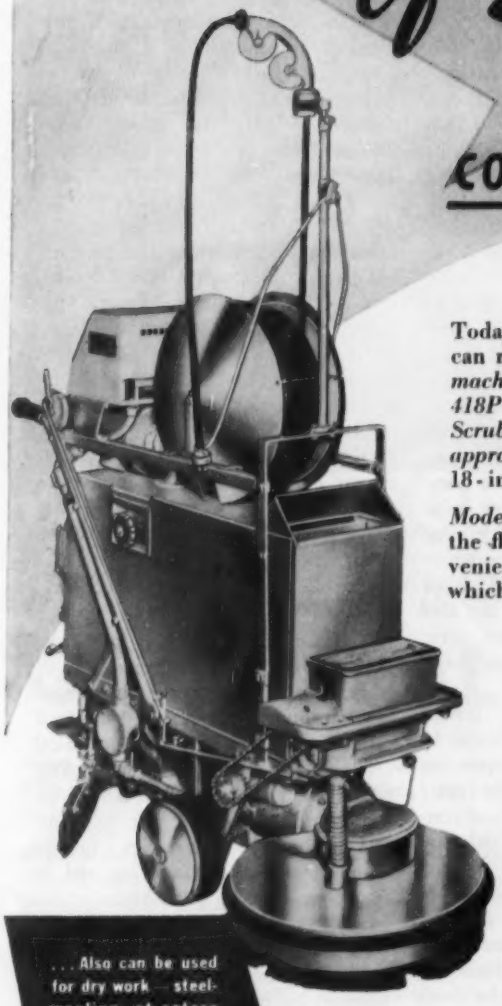

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which automatically sends a single stroke chime and illuminates a light on the receiving master set. The individual who receives the call can reply from any position in the room in which the set is located without the need to touch any part of the instrument. A busy signal automatically locks out and prevents interference, thus ensuring privacy to the stations engaged in conversation. The system also enables all department heads to be in instantaneous contact with one another and there can be as many simultaneous conversations as there are master stations in the system. In addition, secretaries may screen calls made to any and all department heads. The system is designed and installed to provide for extension to new departments as they are developed.

This intercommunication network eliminates the use of internal telephones for calling department heads or their secretaries and thus removes a frequent cause of switchboard congestion as well as loss of time when the called party is not present. It is also more rapid than the dial telephone although such telephones are provided in all offices.

Master sets directly link the offices of the director of nurses, the assistant director of nurses, and the nursing office secretary. Each of these three masters can originate direct calls to all nursing floor supervisors, head nurses, operating and obstetrical room supervisors, the director and assistant director of the hospital, the emergency room, and the central supply supervisor. Floor nursing supervisors can contact nursing offices and the central supply facility directly.

SURGICAL SUITE

Each of the operating rooms, the cystoscopy suite, the fracture room, the emergency operating room and the operating room supervisor's office, the anesthesiologist's office, and the operating room workroom, the doctors' and nurses' lounges are connected by an intercommunication system. In the operating rooms themselves a three-pole explosionproof switch controls the master unit so that calls can be made and initiated from the operating rooms without worry as to explosive gases. Calls can be originated by circulating nurses in their areas for the purpose of obtaining medical supplies, blood, pathology reports, or additional nursing assistance as needed.

The surgical suite intercommunication system likewise links all of the units of the operating suite to the operating room supervisor's office, providing her with instantaneous control of her department. Direct contact is provided, too, from the operating suite to the central supply facility of the hospital and to the office of the nursing director so that when any difficulty arises calls for assistance can be immediately relayed.

Each delivery room is provided with an explosionproof, switch-controlled master unit from which calls can originate to the delivery suite supervisor or to the nurses' workroom. These calls illuminate the name tab of the delivery room from which the call originates on the receiving station unit. These tabs remain illuminated until the call is accepted. Acceptance from either of the two master stations extinguishes the illumination and a line is automatically opened to a two-way communication. This type of equipment, which differs from that installed in all other departments except the surgical suite, is used to make certain that calls do not go unanswered and differs from the other departmental intercommunication systems in that the tab light will not go out until the call is answered. The supervisor of nurses also has direct contact with the obstetricians' lounge and with the nursing station located in the labor suite so that it is possible to ready delivery rooms and order facilities in emergencies with dispatch. All labor rooms in the obstetrical suite are also equipped with an audio-visual nurse call system to be described in detail later in this article.

The intercommunication system also connects the delivery rooms to the fathers' lounge and the doctor can pass on the happy news to the father as soon as the child is born and conditions permit. He does this by depressing a foot switch and talking. Fortunately, the father cannot talk back. This device will save an hour or so of time during which the father may be pacing back and forth although the baby has already been born.

The x-ray therapy, x-ray diagnosis, electrocardiography, electroencephalography, basal metabolism, and the physical medicine departments have all been located in one area in this hospital. Scheduling of patients, reception and traffic for these departments are under a single receptionist control point. Master units are located in the offices of the chief radiologist, his secretary, and the departmental receptionist. Staff stations are strategically placed in the physical therapy and occupational therapy rooms in the E.C.G., E.E.G. and B.M.R. rooms and in the x-ray diagnostic rooms, x-ray therapeutic rooms, in the darkrooms, the file room, the residents' offices, the typists' offices, records room, and reading room. The chief radiologist, his secretary, and the receptionist are able to talk to each other, and also to originate calls to all units in the x-ray departments. In addition, a paging system working through the intercommunication unit connects the receptionist to the diagnostic and therapeutic rooms, to the therapy rooms in the department of physical medicine, and to all of the service units previously mentioned. The value of this system lies in the fact that it makes it possible for the receptionist, by merely depressing a button, to ascertain whether any of the therapy units in any of the departments is free to accept another patient. In turn, the technician in any of these areas can throw a switch which permits him to converse directly with the receptionist in the waiting room. This system will permit more efficient handling of patients and better use of the professionals' and technicians' time. It also speeds up requests for transfers of records and information.

LABORATORY DEPARTMENT

The pathologist, who is the chief executive officer of the department of laboratories, and his secretary have master units on their desks. Staff stations are located in the clinical microscopy laboratory, the hematology laboratory, the biochemical laboratory, the isotope laboratory, the histology and pathology laboratories, in the various research laboratories, and in the morgue. The pathologist or his secretary can communicate directly with each other and each can communicate directly with all of the laboratories in the department. Any of the laboratories can originate a call to the secretary who will screen all the calls for the pathologist so that he will have less interruption of his work. Laboratory employes can originate calls to the secretary's office by depressing a button on their unit. They then return to their work until the signal is given that the call is

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accepted. The secretary learns of the call by a single stroke chime and the illumination of a name tab on the master set indicating the origin of the call. When she is ready to accept, she depresses the illuminated name tab which automatically lights up a red lamp on the unit in the laboratory indicating to the one who made the call that a line is open and that he may engage in conversation. He can talk to the secretary without leaving his bench or from any part of the room without touching the instrument.

A system similar to that installed in the laboratory units is in use in the outpatient department to connect the general office and the reception area, the various examining and treatment rooms, the doctors' offices, the nurses' stations, and the dental and E.N.T. and throat clinics. The system can also be used for paging in the individual rooms and for issuing instructions.

The dietary facilities of the hospital are provided with a system that connects the cafeteria with the main kitchen, the coffee shop with the main kitchen, the main kitchen with the kosher kitchens, and the employes working in these areas with one another. The food service manager has direct contact with all assistants who will be able to reply to him from wherever they may be in the kitchen area without leaving their work.

A similar system is provided for the central supply unit and is under the control of the central supply supervisor. Her office, which is central to all central supply facilities, connects with each of these units and with the central storage facilities. Similarly, the chief engineer of the hospital has direct communication with the boiler plant and with all maintenance shops.

These intercommunication systems were designed to weld all of the elements of this modern hospital into a closely coordinated team. In the last analysis, however, the justification for such an elaborate installation is the degree to which it contributes to the speedy recovery of a patient. With this in mind the next unit to be described probably has the most direct impact.

The nurse, after all, is the critical link in the continuous chain which keeps service responsive to the needs of the patient. To reinforce this link the Long Island Jewish Hospital has installed a new and improved audio-visual call system that permits the patient and the nurse to talk directly with each other without a second's wait at any time of the day or night. This new system combines the advantages of visual (annunciator) signaling system with its dome and duty station signal lights together with the split second speed of voice-to-voice communication.

AUDIO-VISUAL NURSE CALL

The system was first tested by the Hospital Methods Improvement Branch of the Office of the Army Surgeon General at Fitzsimons General Hospital, Denver, and at Valley Forge Hospital, Phoenixville, Pa. The tests show that nurse foot travel was cut by more than 50 per cent while there was a marked increase in the amount of patient care. Moreover, more beds could be handled by fewer nurses so that the operating cost per bed was shown to be reduced as much as 8 per cent. By permitting the patient to talk directly with the nurse the system eliminates dozens of unnecessary trips to the patient's bedside.

A study made recently of 4000 patient calls in a large hospital revealed that 5 per cent were for information only, 58 per cent required taking articles to the patient's bedside, and 37 per cent required direct bedside care. The nurse call system will eliminate "information trips" almost entirely and halve the number of trips required to bring patients articles, because the nurse learns what is needed without a prior trip to investigate. For the patient this system adds a vitally important feeling of security. Every bed and every nursing station in the hospital will have the system available. This system is an advance over those previously installed in that when a call is initiated by a patient this one operation automatically and simultaneously accomplishes the following results:

It (a) illuminates a white indicator lamp on the wall above the patient's bed; (b) illuminates a white dome lamp in the corridor over the door of the patient's room; (c) sounds a chime at the nurses' control station; (d) illuminates an annunciator signal light on the nurses' control set which identifies the origin of the call; (e) sounds a chime and illuminates the duty light on each auxiliary reply station or duty station, and (f) illuminates colored zone lights in various corridors so that nurses in transit have means of rapid identification of the area from which a call has been originated and, by entering that area, can identify the room from which the call originates by the dome light. If the nurse then enters the room itself, she can identify the patient by the light over the patient's bed. Auxiliary reply stations or duty stations are located in utility rooms, nurses' charting and rest rooms, and pantries. Thus the entire nursing unit is controlled.

To reply to a call, the nurse or clerk at the control station merely depresses a button on her unit corresponding to the station originating the call. This connects the nurses' control unit to the patient's call unit and opens a direct line for two-way conversation. At the same time, the corridor dome light above the patient's door is automatically extinguished as well as the annunciator light on the nurses' control station and on all auxiliary reply stations. The nurse may use either an earphone or a hand set. The hand set is provided with a built-in press-to-talk button for convenience and is used when a greater degree of privacy is desired. Should a nurse be in the corridor when a patient originates a call she will see the illuminated dome light over the room or, as has been explained, if she is in a secondary corridor she will see a colored zone light and be directed thereby to the proper corridor.

When the nurse enters the room she depresses the reset button on the patient's call station. This automatically extinguishes all the signal circuits that have been set up and prevents duplicate call acceptance by nurses at other areas on the floor or by acceptance at an auxiliary reply station. Any number of patients may originate calls at the same time and all the signaling lights will remain registered until all calls are answered. As each call is answered all signal lights and audible lights illuminated by that call are automatically extinguished. All other signals remain on until the other calls are answered. If calls are registered while the nurse is using the nurse control station, they will register only by lamp signal so that the chime does not sound and interfere with conversation.

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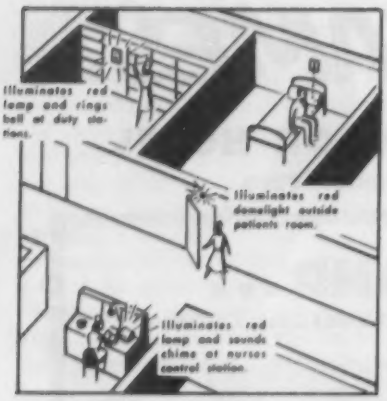

Long Island Jewish Hospital was the first to make use of the bed occupancy monitor, which automatically alerts nurses when a patient who is restricted to his bed moves too strenuously or attempts to get out of bed. The electronic monitor illustrated here was first described by Dr. Rosenfeld in the September 1952 issue of The Modern Hospital.

tored by the nurse at the station at any time of the day or night. The patient's station is so sensitive the nurse can actually hear the patient breathe. However, the patient can enjoy complete privacy if he so desires. A conspicuous red lamp is automatically illuminated when the nurse is listening-in to a patient. The nurse can monitor all patient bedside stations simultaneously or in groups of 10. This call system has foolproof circuits which make visual signaling independent of audio. If the voice operation should be turned off or for some reason of interference or breakdown become inoperative, the patient's call will nevertheless establish all visual signals in addition to the chime at the nurses' control station. Finally, emergency signals hooking in to the call system are provided from all toilet, bath and shower rooms for added safety.

The audio-visual nurse call system described here requires the active cooperation of the patient for he must initiate the call by depressing a button on a hand set. One of the great problems in nursing has been how to devise a passive signal system which would enable the nurse at her station to detect immediately any medically contra-indicated physical activity on the part of a patient. Therefore, a device known as the electronic bed occupancy monitor has been set up so that it ties in with and becomes part of the audio-visual nurses' call system. When a patient attempts to leave his bed against advice the bed signals are activated in the nurses' control station and at the duty stations located in pantries and utility rooms. In addition, the corridor dome light is illuminated. Ordinary movements will not activate the signals but they can be set so that undue activity or attempts to get out of bed will activate them. The device itself is attached to the underside of the bed and therefore not accessible to the patient. Moreover, if care is taken to install it at a time when the patient is not present, the patient need never know of its existence. Installation time is a matter of seconds and if it is used selectively for patients restricted to beds, where the degree of restriction of activity is important or in cases where special duty nursing would ordinarily be used if available, it can be an extremely helpful adjunct to good nursing care.

The nurse call system and the bed occupancy monitor described are only a part of the safety circuit immediately surrounding the patient and assuring swift attention at all times. This circuit, in order to be complete, must provide for the paging of doctors and key personnel as needed. At Long Island Jewish Hospital an ultra-high frequency radio system consisting of a central broadcasting unit and small radio receiving sets has been installed. When he signs into the hospital a doctor will pick up an audible receiver only two inches longer than a package of king-size cigarets and slightly heavier. The set fits comfortably into the breast pocket of the jacket. Each receiver is set to pick up one particular ultra-high frequency signal. When the doctor is wanted, the telephone operator, using a central keyboard no larger than a medium size adding machine, sends out an impulse which activates a high pitched buzzing signal on the receiver set. This signal can be heard readily by the person being paged but by no one else. Eight hundred and fifty different signals, each of them specific, can be sent out through one keyboard transmitter. It can operate 24 hours a day where the conventional loudspeaker system must be discontinued at night to avoid disturbing patients. The ultra-high frequency paging system is also a marked advance over light signals which, though noiseless, may frequently go unseen by the doctor who is being paged. It also makes possible contact with individuals who are on the move or in adjoining buildings on the hospital site or, for that matter, at a distance. The radius for effective transmission is three miles. It requires no wiring or conduits and can be handled by anyone after brief and simple instruction.

By making possible instantaneous transmission of the spoken word, the intercommunications and nursing call systems will bring great improvements in patient care and administrative efficiency. But unless the spoken word can be supported rapidly by information in a more permanent form by preoperative, postoperative and follow-up notes, history and physical examination reports, full advantage of the other systems will not be realized. Frequently, rapid availability of a postoperative report or diagnostic report can be of vital importance should an urgent problem arise concerning the patient's condition. The medico-legal and teaching values of complete and up-to-date permanent records are well known to all hospital personnel.

To provide speed, accuracy and completeness in the transmission of such reports the hospital has installed a network of wired remote control dictation facilities consisting of dictating stations and a transcribing center. Each station has an instrument that closely resembles the conventional telephone. The doctor who wishes to dictate a report has merely to lift the receiver from the cradle of the phone and press a talk switch in the handle, which automatically starts or stops a recorder in the transcription center by remote control. A playback and correction button on the base of the dictating instrument enables the dictator to listen back or mark a correction. The report is recorded on a central recorder located in the transcription center which itself is part of the central record room facilities of the hospital. This center is the point at which both the recording and transcribing functions are performed. Basically, it consists of recording instruments with their

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power supply, disk files to hold disks between recording and transcribing operations, and a secretarial transcriber on which the transcriptionist can play back the disk at her own speed and convenience. A buzzer automatically notifies the transcriptionist when a new disk is required for the recorder. It takes but 4 seconds to change a disk or an average total of approximately 45 seconds per day.

Each group of dictating stations in the hospital is connected or wired to a particular recording machine. By means of a selector switch on each station, the dictating instrument can be switched to two or three recorders. When the dictator picks up the phone at his station, a red signal light is illuminated not only on his instrument but also on all other instruments connected to the same recorder. In this way the line is reserved for him throughout his entire dictation and all others are notified of this fact. The number of recorders per dictating instrument and the number of recorders for the hospital are based on an average peak load figure which has been worked out for hospitals of similar size and programs.

LOCATION OF STATIONS

Dictating stations are located in the following hospital areas: all the doctors' chart rooms, one on each nursing unit, the doctors' conference rooms, one on each floor, the doctors' lounges, the x-ray offices, the film viewing and conference rooms in each department, all doctors' offices, all examining rooms in the outpatient department, the nursing supervisor's office in the emergency suite, the surgeons' lounge (where there are two stations), the dental laboratory office, the record room library, the offices of the director of laboratories, the necropsy suite (where there are two stations), the research laboratories, the stenographers' pool, the staff lounge and conference room, the board room, and the executive director's office.

Where freedom of hands is important, as in the necropsy room, the station consists of combination microphone and receiving head set with foot control, and control box with the playback switch. This frees the hand of the operator for his work on the necropsy table, and enables him at the same time to dictate his findings.

An important link in the hospital's communication and transportation network is a pneumatic tube conveyor system modeled after those commonly in use in department stores and reaching to every nursing station and department in the hospital. The tubes will carry reports, messages, instruments and medication swiftly wherever they are needed. The central terminus is located in a room adjoining the record room and transcriptionists' center. Substations strategically located on each floor can be used both for receiving and sending. Tubes sent between substations are relayed at the central terminus.

PNEUMATIC TUBE SYSTEMS

Since vacuum tube systems are not useful for large objects and since many objects need transport in a hospital which do not require elevators or need not be accompanied by a porter, the use of dumb-waiters has been traditional. However, a time and use study of conventional dumb-waiter installations has shown that even as the single isolated elevator is inefficient so the single dumb-waiter is inefficient. Modern buildings always group elevators for maximum efficiency. At the Long Island Jewish Hospital a battery of two dumb-waiters serves each nursing unit in the hospital. However, the two dumb-waiters in each battery are designed for different purposes. The larger will take a cart about the size of the standard surgical cart and all routine supplies can be directed to each nursing unit without being accompanied by personnel on this large dumb-waiter.

Emergency service of smaller articles, trays and packs which are too large for the vacuum tube system, will be sent to the nursing units by the smaller dumb-waiter. Thus, with two in use, delays are cut to a minimum and the routine usage for transport is greatly increased and the personnel required for the delivery of equipment and supplies is minimized. This factor also releases the elevators which in the Long Island Jewish Hospital are grouped for the transport of personnel, visitors and patients, not equipment and supplies. It should be said that a battery of four elevators has been provided for a six-story building with a capacity of 214 beds and 40 bassinets. However, wells are present for the future installation of two elevators when four floors and 300 more beds are added to the building. The dumb-waiters mentioned have access doors on each floor directly opposite the nursing station. These doors cannot be opened except when the cage is in place and are provided with a combination of visual and audible chime signals to indicate the arrival of the cab.

Consideration was given to the installation of a conveyor belt from ground to top floor to replace the dumb-waiters and supplement the other systems of the hospital. But, after considerable deliberation, it was decided that the battery of dumb-waiters on each side of the rectangular building would be more efficient, less noisy, and perhaps as useful. However, for economy purposes and for strict controls, all sterilizing and autoclaving equipment except emergency equipment for operating room and obstetrics were placed in the central supply facility.

Employes in the operating suite and delivery suite and all nursing units will be instructed in the system whereby all packs, trays and sterile goods for routine use will be made up in central supply. To facilitate delivery of operating room supplies, a decision to install a continuous chain belt conveyor system from the central supply service to the surgical suite was arrived at. This installation makes it possible for the personnel in the central supply to do all of the major standard routine autoclaving and sterilizing and packing for the operating and obstetrical suite and to deliver these goods and receive used goods for repacking and sterilizing by continuous chain belt conveyor, thus saving both the time and energy of personnel formerly required to carry these materials, as well as speeding up their delivery.

The various systems of communication and transport which have been discussed here are designed to save hours of personnel time each day. They will assure that the maximum amount of professional skills are directly devoted to the recovery of patients. By substituting push-buttons for personnel wherever it has been possible to do so, the Long Island Jewish Hospital intends to provide hospital service that will be humane because it is more efficient and more efficient because it makes use of the latest knowledge in communication and transportation available to the hospital field.

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GENERAL PLASTICS

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Recommended Lighting Practices

(*Continued From Page 87*)

rooms. About 200 ft-c on the table is recommended.

ANESTHESIA, PREPARATION ROOM

Lighting in the anesthetizing and preparation room should be about 20 ft-c. Indirect lighting is desirable to minimize glare to supine patients.

HAZARDOUS AREAS

Rooms in which combustible anesthetic agents are stored or administered require special consideration because of the fire and explosion hazard.

Switches, outlets, lighting fixtures and other electrical equipment are required to be explosionproof in the entirety of anesthesia storage rooms, and also to a height of 5 feet above the floor in operating, delivery, emergency and preparation rooms.

RECOVERY ROOMS

Lighting in the recovery room is more critical than in ordinary nursing areas of the hospital. The brightness from fixtures and background should be kept as low as practicable so as not to add to the discomfort of the patient, but at the same time the lighting should be sufficient for the nurse to observe any appreciable change in patients' color and to render proper care. About 20 ft-c is recommended. Emergency lighting should be provided for this room so that proper observation and care will not be interrupted because of an outage of the main electric service.

NURSERIES

Nurseries for newborn and premature babies should have about 20 ft-c. Emergency lighting should be provided.

PSYCHIATRIC WARD

In the open section for quiet and depressed patients, lighting can be as specified for medical and surgical nursing units.

In the disturbed patients' areas, fixtures and control switches should be of types and so located as to be difficult for patients to damage or use as a means of harming themselves or others. Flush mounted fixtures with shatterproof, or heat treated, or wired glass covers which can be opened only by a special tool are recommended.

These fixtures are generally located in the ceiling for security reasons but may be located in the wall near the ceiling. Reading lights are not required. Night lights with safety features similar to those for general illumination should be provided. They may be individual units or in combination with other lighting fixtures. For cleaning work and other incidental tasks, 10 ft-c should be provided.

Switches for control of lighting in the disturbed patients' areas should be key operated or located outside the rooms and inaccessible to patients.

ELECTROENCEPHALOGRAPHIC SUITE

This suite usually consists of an office where patients are interviewed, reports are made, and records are kept, an adjoining workroom or space where instruments and supplies are stored, and a patient's room.

As it is important that patients be relaxed and undisturbed during tests, a warning signal light or lighted sign in the corridor at the suite entrance indicating the suite is in use is recommended. About 5 ft-c or less is recommended for the patient's room. Ordinary lighting of about 30 ft-c for the office and 20 ft-c for the workroom is satisfactory.

EKG, BMR AND SPECIMEN ROOM

Indirect lighting of about 10 ft-c is recommended for general illumination as it is desirable to create a quiet and soothing atmosphere for EKG and BMR patients.

About 30 ft-c is needed at the table where blood specimens are taken.

PHARMACY

The general illumination in pharmacies should be about 30 ft-c. Supplemental lighting of about 50 ft-c is required at the prescription counter where medications are compounded and dispensed and at such other work counters where reading of fine print on labels, graduates, balances and the observation of preparations for clarity, color and consistency are required.

In the alcohol storage vault, lighting fixtures and control switches may be required to be explosionproof depending upon the containers used and the inspection authority having jurisdiction. Consult Sections 5002 and 5004 of the National Electrical Code.

LABORATORIES

Laboratory offices and work areas should have about 30 ft-c general illumination. Fixtures should be so located as to provide 50 ft-c or more on the work benches.

The lighting should provide a color effect as near as possible to that in which such tests and observations are ordinarily viewed. Natural daylight and incandescent filament lamp lighting are generally preferred. However, de luxe warm white fluorescent lamps have color characteristics close to that of filament lamps and are generally quite satisfactory except where extreme color characteristics are required.

EYE, EAR, NOSE AND THROAT SUITE

A variety of lighted instruments is used in the eye, ear, nose and throat suite for which a considerable number of convenience outlets should be provided. A duplex outlet at about every 5 feet around the periphery of each examining room is needed for flexibility. Additional service outlets may be required where treatment stations will be located. During the use of lighted instruments it is important that the general illumination be low, about 5 ft-c or less, and for some examinations complete darkness is required. However, a maximum of about 20 ft-c general illumination should be provided for occasional use.

Because of the frequent need for switching the room lights during examinations at any one of the various examining stations, switches should be located as conveniently as possible.

DENTAL SUITE

For seeing comfort and efficiency in the dental operatory, a reasonable balance should be maintained in the lighting at the patient chair, the instrument cabinet, and other areas of the room. As the dentist may frequently turn from the patient to the instrument cabinet the ratio in brightness at the

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Other items shown in the above room scene are: No. 2003 Bedside Cabinet, No. 20-614 Overbed Table, No. 2004 Dresser Base with No. 20-05 Mirror, No. 2008 Arm Chair, No. 20-07 Straight Chair, and No. 305 Lamp.

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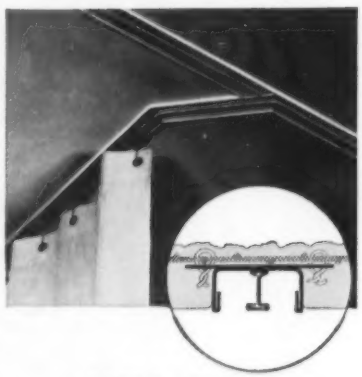

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patient's mouth and at the instrument cabinet should be not more than 3 to 1. Brightness of remote areas of the room should be within one-tenth that at the patient's mouth. As the various dental operating lights commonly used provide 400 to 600 ft-c at the patient's mouth, about 150 ft-c should be provided at the instrument cabinet and at least 40 ft-c for general lighting.

At least 50 ft-c is needed at the laboratory bench for technicians.

Lighting for color distinction in the matching of teeth should be provided. For best results two lighting sources are suggested: one from filament lamps, and one from de luxe cool white fluorescent lamps, used separately for averaging the color effects.

The waiting room should have about 20 ft-c of lighting for casual reading.

A rather low intensity of lighting, 5 ft-c or less, is desirable for the recovery room where patients may rest after administration of anesthetics, extractions or dental surgery.

NECROPSY ROOMS

Necropsy rooms and particularly the necropsy table must be well lighted for critical observation of tissue and specimens. At least 30 ft-c for the room and 200 ft-c for the table is recommended. A large low-brightness, non-adjustable ceiling suspended lighting unit, such as the concentric ring louver type with silvered bowl lamp, is often used for the table light. However, some advantages are claimed for a ceiling suspended lighting unit adjustable for vertical and horizontal positions and for beam spread, somewhat similar in design to a minor surgical lighting unit.

X-RAY ROOMS AND FACILITIES

A fairly low level of lighting intensity, about 10 ft-c, is sufficient for radiological rooms.

Rooms used for fluoroscopy must provide means for darkening. A small amount of light, about 1 ft-c, is desirable when the physician will need some illumination during a fluoroscopic examination yet does not wish completely to lose his eye adaptation to darkness.

Darkrooms, in addition to the safelights for handling undeveloped film, should be provided with 10 ft-c of ordinary lighting for preparation work and for cleaning and maintenance.

RADIOISOTOPE FACILITIES

Lighting intensities for general illumination in these areas are not critical, and need only be about 20 ft-c in the patient uptake measuring room and 30 ft-c in the radiochemical room. The examining and treatment table should have about 50 ft-c. Standard fixtures easily cleaned and relamped are satisfactory. Incandescent filament lamps are preferable to any of the gaseous discharge lamps, such as fluorescent, because the latter sometimes interfere with the accuracy of radiation measuring instruments.

EXITS AND STAIRS

A fairly low level of lighting intensity is usually sufficient for exits and stairs; 5 ft-c for exits and 10 ft-c for stairways are recommended. Exit lights should be located so as to be readily seen by those approaching the exit.

Circuits for exit and stair lighting are required to be connected to the emergency lighting system. Minimum requirements for lighting of stairways and exits are given in the Building Exits Code.

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lecture need only about 10 ft-c. Where used for exhibits, 30 ft-c should be provided. As portable projection machines for slides and motion pictures are often used in auditoriums, the lighting should be arranged for operation by means of remote control switching at the projection machine. This control should be in addition to the usual wall switches. A receptacle should be conveniently located for plug-in of a small shielded light on the lectern. Glaring lights which may be annoying to the lecturer or the audience should be avoided by location or shielding. The application of dimmers should be considered for auditorium lighting.

EMERGENCY LIGHTING

As a minimum, emergency lighting should be provided for surgical and obstetrical tables, exits and exit-direction signs, stairways, some corridor lights between patients' rooms and exits, all nurseries, recovery rooms, telephone switchboard, and boiler room. Switching to and from the emergency service should be automatic. A typical arrangement for emergency lighting is shown in Fig. 1 on page 85.

As previously mentioned, fluorescent lamps are not suitable for switching from A.C. to D.C.

Power for signal systems and other services, including iron lungs, not covered in this paper, are usually required in addition to that for lighting.

OBSTRUCTION LIGHTING

When obstruction lights for airplane warning are required on high portions of buildings or smoke stacks, they should conform with the latest recommendations of the Civil Aeronautics Administration. Where obstruction lights are installed they should be connected to the emergency service.

PARKING LOTS

Hospital parking lots should be lighted to an average intensity of about 2 ft-c and a minimum of about 1 ft-c. Steps leading to parking lots should have about 5 ft-c. Injuries to patients and visitors resulting from unlighted parking lots have, in some cases, resulted in court decisions holding the hospital liable.

Recommended lighting intensities are given in Tables 1 and 2 (*pp.* 86 and 87). Table 1 shows recommended footcandles for normal lighting. Table 2 shows the minimum footcandles for emergency lighting.

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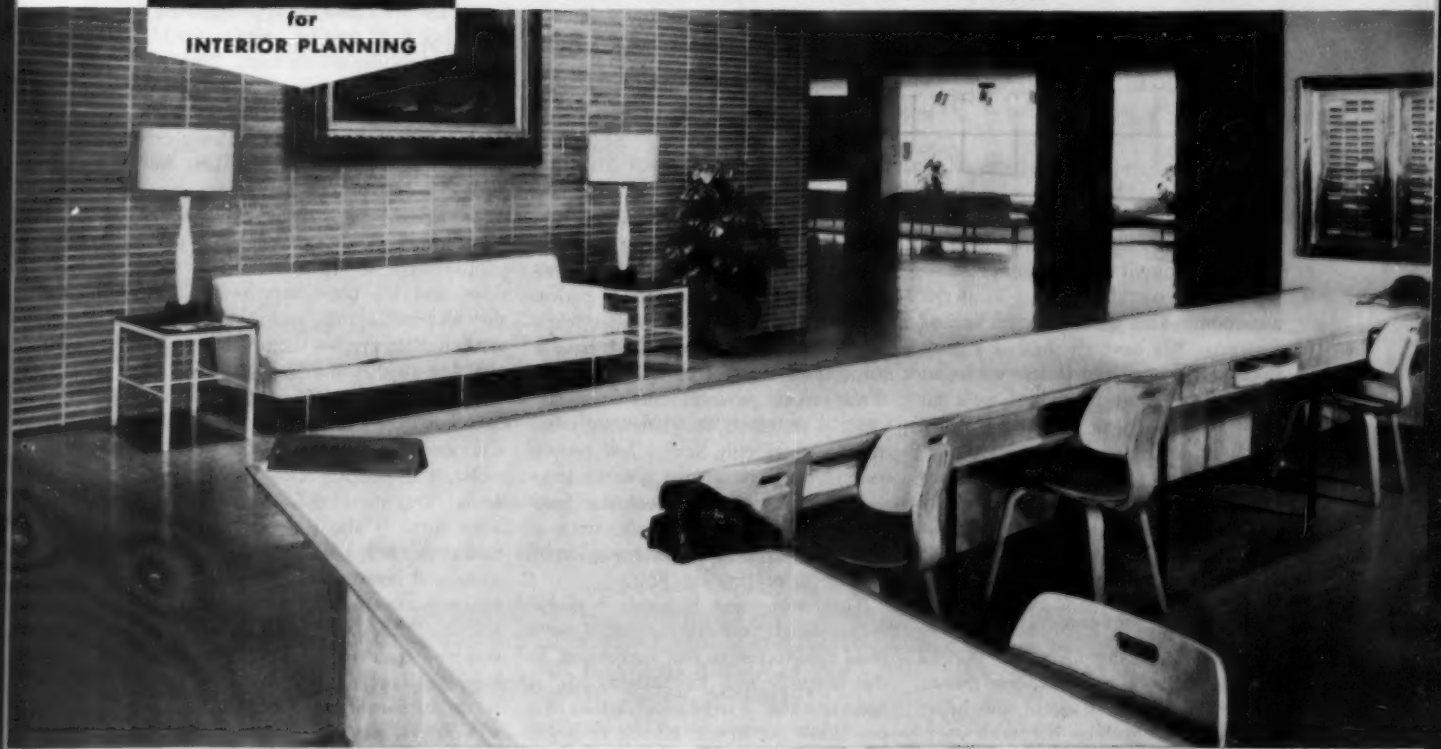

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Lessons in Good Housekeeping

Basic Technics: Machine Scrubbing

EMILY C. DEMING
Executive Housekeeper
Butterworth Hospital, Grand Rapids, Mich.

IN THIS fifth section of her series of lessons in good housekeeping Miss Deming takes up the problem of machine scrubbing, including the use of the wet and dry vacuum cleaner. This class is given just to the housemen. In preceding lectures, Miss Deming has discussed the introduction to the hospital, equipment used in housekeeping, and the basic technics of sweeping and mopping. Next month's lesson will be on waxing, which will conclude the material on care of floors. In subsequent issues, the lectures will cover such topics as dusting, window washing and screen care, wall washing and spotting, window treatments, getting the room ready, follow-up, waste disposal, and safety.—Ed.

GOOD morning. From the amount of equipment we have here it rather looks as if the class might find itself in the corridor looking in at the classroom! This time the class is just for men. We have all the heavy duty floor equipment here. Before we begin any discussion of procedure we'll go over the machines themselves very carefully.

We have the scrubbing machine, or the floor machine as it is properly named, because it not only scrubs but polishes, buffs, dry-cleans, steel-wools and so on. Then we have the wet and dry vacuum cleaner, and I'm sure some of you had never met a vacuum cleaner capable of picking up water as well as dust until you came to these classes. In addition, here is all of the heavy mop equipment—the big tank mopper, the big double dolly, down to the small sized general use double mop pails. Then we have wax, wax pan, and the wax applicator, the "WET FLOOR" signs and holders.

Now we spend a lot of time sweeping, mopping and dust-mopping floors. That's for their normal care and maintenance. Today we're going on into the machine scrubbing of floors. After an area has been in use for a period of time, depending on whether it's a main entrance lobby where we have a tremendous amount of traffic, or one of the private pavilion units where the traffic is restricted, *i.e.* there's no cross traffic and we only have a few people coming and going, we have to strip the old wax and soil from the floor and re-do it once a week, once a month, or we may only have to do it two or three times a year.

This equipment is good. It's also expensive. It is necessary that it have good care to return that investment to the hospital and its patients. It is necessary that it have good care so that you don't get in the middle of a job and suddenly find your machines going out of order, so you have to finish the job manually and perhaps have to stay overtime to do in four or five hours what you could have done in two with the machines. There's also a matter of pride in keeping our equipment beautifully clean and in shining condition.

Wherever cleaning procedures are taking place on floors there is the safety factor: for yourself, for the people going to and fro as you work, for everyone concerned. Now we have these sign holders, and signs that say "WET FLOORS." In certain areas we also use this rope to rope off the floors. The standards are approximately 30 inches high so that people should have no difficulty seeing them. They're bright red. They must *always* be up when we are doing a floor area of any size. In order that the public may be perfectly safe—that our staff may be safe—we do only one-half of the corridor lengthwise at one time. We never work across the hall so that people have to walk over the wet floor, and we hope very much that they will walk on the area that we have carefully left dry for them.

What do they sometimes do? How very right you are. They will even on occasion step over the rope into the wet area, won't they? Who offends worst, the public? Or—you're right again. Our own staff. I don't know what there is about a wet floor that seems just to fascinate people, but there will invariably be some one person, or more than one, sometimes, who will hop over and step onto a wet area and track it up. Now, when that happens if you notice that somebody is coming into it say, "Oh, please, we're working on this side. Won't you walk on this area that we've left dry for you? It's safer." If they've actually got into it say, "Oh please, sir—or please, ma'am, this area is wet and we don't feel it's safe for you. We've marked it off, won't you please go over on the other side?" If they've stepped

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over your rope, drop it for them. Now I know it's a nuisance, and I know it makes you cross, but you mustn't under any circumstances let the crossness or the nuisance show in your voice or manner. Do try to be courteous no matter how irritating you find a member of our own staff or of the general public. It's our job to do basic service in spite of, because of, and no matter what, to do it pleasantly and do it well.

BE SURE IT'S PLUGGED IN

Electricity and water don't mix. You can get a nasty shock if you abuse your equipment. Certain fundamental things in the use of these machines you *must learn*, practice and never fail to observe.

You will note that these heavy duty machines have rubber covered cables rather than cords to connect them. This particular floor machine has a plug right here behind the motor, and many times when you come down to my office wild-eyed and tell me your machine isn't working, and I trot myself up to the floor and take a look, you have for some reason or other plugged this out and forgotten to put it back in again—and then you feel silly and once in awhile I feel cross because we've wasted valuable time: yours and mine too. So, the first thing to do is to be sure that your machine is clean, your cable is free of soil or breaks, and that all of the plugs are properly inserted.

The cable, when you are working, is carried over your shoulder; a loop of the cable is caught in your hand so that it prevents a sudden motion of the machine from jerking the cable and breaking a wire in it. The cord is raised over your shoulder solely to prevent its becoming entangled in the machine. When you are doing wet scrubbing it could be very serious indeed, and give you a hard shock if you happened to strike the cord and break the rubber insulating covering and water got into the wiring. It would also put the machine out of order until we had had time to take it to the shop for repair.

When you remove the cable take off the amount that you are going to need. Have a comfortable working play; leave the rest of it on the cable hooks. Do you notice anything unusual about the way the cable is wrapped on the hooks? It doesn't just go around and around—what does it do? It makes a figure eight. Have you any idea why? Well, you will discover that if you wrap your cord or your cable when you are using electrical equipment in a figure eight on your cable hooks or vacuum-cleaner holders that you wont have any kinks when you play it off for use. It's just a simple safety and time saving device. And always wipe your cables and cords clean with a damp cloth as you rewind them. This does two things. It prevents the cleaning compounds from rotting the rubber covering and allows you to inspect the cable for any damage and report it at once. The rubber hand grips are equally important. If any wear is apparent, report to your supervisor as you check the machines into the storeroom.

We have here a tank which is attached to your machine in this manner. The small hose is connected to this little jet which permits the water to flow down into the brush. The bolts are fastened in this way. The machine is set with a small feed lever so that you can operate it comfortably with your fingers.

A BRUSH FOR EACH PURPOSE

Next we have a variety of brushes. I want you to feel and observe each one carefully so that you know exactly which to take when told to get a bassine or a tampico brush, or some other kind. There is this heavy coarse brush which is made of bassine, this medium one which is made of palmetto fibers, and this fine, very soft tampico brush used for polishing wax. We have here a braided steel wool pad used for burnishing and for dry cleaning. We have a flannel pad used for taking the highlights out of the wax on soft floors and giving a nice final finish to it, and we have a burlap pad that serves much the same purpose on the hard floors.

Then we have this other brush that I'm sure most of you have never seen before. It is a steel bristle brush, a wire brush. Can you guess what it may be used for? Well, think back to how we classified our floors. What were the two general classifications that we used? Right! Hard and soft! Which brush would seem logical to use on our soft floors? Actually you may use a steel wool pad in a few instances. Generally, you use the bassine brush for scrubbing; of the two I prefer the bassine brush and for most of your work that is what you are taught to use. The palmetto brush is sometimes used for buffing down the first coat of wax; we replace it with the tampico for our final polishing after the second and third coat, depending on the type of finishing and the number of coats we are giving. Generally speaking, on terrazzo, finished tile, and so on, we use these same scrubbing brushes. Of course, we do not wax these floors in the same way we do soft floors. Now, what does that leave for us to scrub with our steel brush? That's right! We would use it on unfinished hard floors, that is, poured concrete in the work and shop areas that does not have a paint or finished surface of any kind on it. We will use it very seldom, but occasionally when we are giving these floors a very heavy duty scrubbing this brush is used; or if we are etching a cement floor for painting this brush is used.

All of the floor machines we have are single brush machines. That isn't true of all floor machines. In some places you work you will find that the machines have more than one brush.

For our machines there is just one way of putting any brush on, and don't ever let me catch one of you doing it any other way! It can hurt you, and it can seriously damage the machine. You lay the machine back on its handle, straddle the head, lift the brush you have chosen to use in both of your hands, note where the slots are (you know where the dogs are on your machine), you fit them together and give your brush a quarter turn. You are then ready to set your machine down on it. Don't ever under any circumstances run the head of the machine over a brush so that it catches and goes into position. You can seriously damage both the machine and the brush.

NEVER STACK BRUSHES

These brushes are expensive, expendable items and must be carefully cared for. Never leave a machine standing on the brush. It splays the bristles and makes for uneven wear. This causes spotty floors—even a machine growl sometimes results. Clean brushes carefully before storage. Store them singly on the hang pegs, or place them bristles up on the shelves and NEVER stack one on top of the other.

Most of you have used the machines and know the simple basic "twosome" on which they operate: raise to the right; lower to the left—just as you see me doing it here. There is one difference. Where did I start the operation of the floor machine? Right

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straight in front of me, didn't I? How does that differ from the way we start most of our other procedures? That's right, to sweep, to mop, we start to one side of the area over which we're to work. We start the floor machine directly in front of us because it is a mechanical device operating under electrical power at more or less speed depending on the pressure of our hand on this small lever. If we were to start right by the baseboard and we didn't have perfect control over it we might bump the baseboard or bump a piece of furniture or cause some damage before we had the machine under control, so we start directly in front.

I'd like you to move the machine in as straight a line as possible, and you'll find that with practice you can go almost straight across your body. Raise right, lower left! Raise right, lower left! Observe that you don't do as large an area as you do with your other strokes. About 3 feet is as far as most people can go comfortably. You should never reach to get the side. My arms are short and I can't even do quite 3 feet—about 32 inches is as far as I can go comfortably. One or two of you lanky lads with long arms might do 4 feet and do it very comfortably. Find out what is comfortable for you, divide your space into areas of that width, and then work that way. Note we are doing the same thing we have done in all of the other basic operations: We are moving in a straight line, not running back and forth here and there across the floor whether we are scrubbing, buffing, finishing, dry-cleaning or whatever.

When we make up a cleaning solution to go into the machine tank we make it in a bucket and then pour it into the tank proper. The normal concentration for scrubbing is 4 ounces to the gallon, and on soft floors you are using just good warm water. For a stripping operation the water temperature is a little higher than it would be for just ordinary mopping. In this extra pail you make up about 1 gallon of the same strength and temperature solution to use with your gong brush and hand scrub.

USES OF WET VACUUM

Before we go on with the scrubbing operation we are going to have a look at the wet vacuum cleaner. This machine is designed to take the soil off the floor and to eliminate much of the time needed in the rinsing operation. It is also a godsend when a pipe bursts or we have a flood of any kind. The head is applied in this manner: You *must* be sure that the machine is set for *water* or *dust* so that you don't get into serious trouble with your motor. Check both your hose connections. Check your wand connection, and be sure that the squeegee blades on your pickup are in good condition—so that it is tight and you will have good suction. Check the machine cable. The same rules for care and use apply to the cable of all machines. This one is cared for just like the cable of the floor machines. Observe that on this machine there are no cable hooks, and the cable is looped loosely around the top of the machine here below the motor housing.

We're going to demonstrate this machine by putting down some water here with a mop. Use a short stroke. I can reach about 3 feet. Most of you boys can reach a bit farther. You will notice that if I dry across the floor with a pretty flat motion I leave a good deal of water. However, if I put the wand, when I lower it, to go forward so that the forward blade of the squeegee head is slightly off the floor,

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and raise the rear blade slightly as I pull it back toward me, you can see the floor is practically dry. Now, if heavy soil and accumulated wax and dirt are picked up this way the rinsing operation is actually a nominal one. It's true there are many areas in which you cannot use this machine, simply because with the high ratio of occupancy and the tremendous amount of traffic that we have it isn't possible to have this much equipment in the hall without creating a traffic and safety hazard; therefore we have to go the long way around the barn and rinse by hand. That we have covered pretty completely in our lesson on mopping and I'm not going to review it with you this morning.

Now, looking at all this equipment, what would be one thing we would have to allow for very definitely as a time item in doing a scrub-strip operation on any floor? Yes, we'd have to allow time to take the equipment to the area we were working in and plan time enough to take that equipment back, to clean the floor machine, to empty our vacuum cleaner [Note: demonstrate this procedure], to wash and dry the scrubbing tank on the floor machine, wash and dry the tank of our wet and dry vacuum, and put all of this equipment back in place. Now that's a much larger time allowance than is given for average cleaning. It is our first consideration —transport the necessary equipment we are going to use, and mark the space to be cleaned carefully with safety signs, "WET FLOORS." Then the second thing we have to think of is—what? Making up the measured solution and getting the rinse water, and having all of these things prepared.

It's just possible that before we actually make up the solution we might be able to do what we're going to call the third step. It depends on the area in which we work whether this is step No. 2 or No. 3. If you are doing an office in which the occupant might pop back at any minute, you would wait until the last possible moment to dismantle that office and you would put it back into shape in the least possible time, wouldn't you? If you are doing the big auditorium, one of the classrooms, or a demonstration area you first clear it of all of the furniture and obstructions you can possibly move, then make up the solution to go on with the actual scrubbing. So, depending on what type of area you're doing, No. 2 may be the preparation of the solution, the rinsing water, and the hand scrubbing solution, or it may be the moving of the furniture and all of the portable objects out of the area, so that you have as unobstructed a space as possible in which to work.

TAKE UP LOOSE LITTER

Now we get down to the actual scrubbing operation, don't we? And we mustn't forget when we're concentrating on scrubbing today that before we can scrub we have swept up all the loose litter, all the trash and debris, and all of the dust that we possibly can. In some areas before we start in with this scrubbing operation we have used our vacuum as a dry cleaner to get all of the particles of soil off the floor that we possibly can, because the less loose litter there is on the floor the faster the scrubbing operation is going to be.

To know how to put the solution down evenly, to put on enough and not too much is rather tricky, and so we're going to practice, each one in turn. If you are doing a tile floor,

say an asphalt tile or a rubber tile floor, would you want to flood that floor with as much water as you can put down just as fast as you can put it down? No! Of course not! You'd want to put down just enough to do a good cleaning job, leave it on barely long enough for the chemical in the cleaner and the scrubbing action of the brushes to loosen the soil, and then get it off the floor just as fast as you can with your vacuum cleaner or your rinsing mop—whichever you are using—in order not to damage the back of that flooring and cause the tiles to loosen.

You can use a little more water on a terrazzo or a ceramic tile floor. If you are scrubbing one of the conductive floors in the operating rooms you use a great deal more water, and you use also a good deal of water if you are working on one of the unfinished floors.

DON'T LET AREA DRY

Now, for this moment let's concentrate on the scrubbing of a soft floor and each one of us in turn will demonstrate how to put the water down, how to move our scrubbing machine. We will, of course, be going backward, won't we? And in a straight line. We will never never walk through the heavy soil after we have scrubbed it off the floor. We will never do so large an area that the soil has a chance to dry and redeposit itself on the floor at the beginning of the section we have done before we reach the end of that section. And it will be necessary to remember that we have to have time enough to pick up all of that area before any of it dries during our rinsing operation, whether we are using the vacuum cleaner or a mop to pick up the loosened dirt in the solution we have put down.

This time we are going to use the vacuum so that each of you may learn to use it. You push away from you at the beginning of the stroke and what you want to do is to pick the dirty water up, isn't it? Therefore, you raise the front blade just a tiny bit—just enough to get the water sucked up. If you raise it too high you destroy the suction, and you don't get it picked up. See here? I'm not getting any pickup now; the blade is too high. All right—now watch! I'll lower it just this much and I get a little drizzle. I put it down so—and see how nice and clean it comes? All right. This is the forward half of the stroke and for the final drying I put the front blade in tight contact with the floor and raise the back one just a trifle and pull back. This sequence is done so that if by chance I step onto the floor I'm not tracking soil about.

You know my old maid tactics in keeping things tidy while we're working, and I always believe in having a little foot scrubbing pad with you just like this old piece of mattress padding on which we'll wipe our feet if we accidentally get them soiled in the work process. That will prevent our putting any trackage on the floor. It's just a quick way of saving time.

And now, no matter what we do to a floor, if it's a wet operation what do I always tell you that you can never skimp on and never do too thoroughly? Well, that was a beautiful chorus! Of course. It is to *rinse*. You're going to use just warm water, not quite as warm as you used for the cleaning solution on a soft floor; you can use really very warm water on an unfinished cement floor, and warm to your hand—good and warm—on a terrazzo floor. Rinse thoroughly. Change the water frequently. Use the same stroke that you have been taught in the mopping classes and you can't go wrong.

No matter how clean and dry the floor looks after you have wet vacuumed it, you *cannot skip the rinse!* Prove this for yourself. Rub your hand on the seemingly clean floor. Here is a spot—do you feel the "roll" under your fingers? That is residual cleanser; it could cause a fall and would cause the wax to roll, to be slippery and dangerous.

SCRUB EDGES BY HAND

Now we have something left over, don't we? We have this little bucket over here with a gong brush and a hand scrubber in it. Now what do you suppose I have that made up for? I'm awfully afraid you're right. It's for scrubbing the edges where the machine won't go. Actually, when you're blocking out and doing an entire floor you do the inaccessible places, the spots that you can't reach with the machine, by hand before you begin your scrubbing operation. You scrub, you pick up the soil, you rinse. If you're working in a team of two, as I sometimes have you do, then while the man who is doing the squeegee and rinse operation does his part of the job the man who is on the scrubbing machine has gone on to the next space with the gong brush and the hand scrub and is getting into the corners, under the radiators, behind the doors, and in all the little cubbyholes where the machine won't go. That way you don't lose any time.

You must always have with you—that's right—a cloth dampened in clean water to take up all the spots. Watch carefully, because occasionally a brush will spatter; or in handling a mop where you have heavy soil you'll get a spot on a wall or on a piece of furniture that couldn't be moved, and that must be taken up immediately with clean fresh water so that there won't be any soiling of the wall or spotting of the furniture. And no matter what we are doing, we never never let a brush strike a wall, a door, a piece of furniture, the leg of a chair, the underside of a desk, the cord or any other area except the floor. You can learn as you practice with these machines just to whisper up to the mopboard and slide back out again without leaving a mark of any kind, while getting your floor just as nice and clean as can be.

TIME TO CLEAN FLOORS

What happens to the brushes of our machines if while we're waiting to go on with the rinsing and mopping operation the brush bears the weight of the machine, the scrubbing tank, the water? It just splays out like a tired old hound dog's tail. One of the first things we learn is that never at any time do we let the weight of the machine rest on the brush. We have some machines with a retractable brush so that you don't have any problem. There is a problem of preserving the bumper of your machine in good condition. The bumpers are made of rubber. Your cleaning solution will have a disastrous effect on them if you don't wash the bumpers clean when you've finished using your machine, and put it away with the bumper perfectly fresh and clean.

The best time study that I know of on the scrubbing of floors gives as total time spent in scrubbing operations:

1. General preparation, including transportation of equipment, 38 per cent of total time spent.
2. In actual scrubbing, 37 per cent.
3. In picking up of soil, 14 per cent.
4. Rinsing of floor, 11 per cent.

The waxing operation will be covered in the April issue of this magazine.—Ed.

Nursing Calls Housekeeping Blessed

(*Continued From Page 95*)

mishing, it was decided that the head nurse would order what was needed. However, if the head nurse misjudged and didn't order enough, the patient was without linen. Or if she ordered too much, the superintendent of nurses or someone would come along that day and discover that she was a poor manager.

Now all this is changed! In the morning during the first minutes after 7 o'clock a large cart arrives with the *neatest* linen packs! All the nurse has to do is take her allotment along with her on one of her trips to the patient. This is wonderful, because it eliminates ordering today for what you think you will need tomorrow. How does it happen? Because behind the scenes, the housekeeping department has checked the business office census, so we will get exactly what linen we need for the patients we have—and all without any effort on the part of the head nurse, the ward clerk, the assistant director of nurses, and so on.

The days when linen and laundry were a mystery were also the days when there was only a floor maid, and she was expected to keep only the floor and the glass panes in the door clean. Nursing did most of the dusting and cleaning around the patients. Surely all nurses remember the frantic scrubbings we gave units during the years when we had to take time from our patients to do it. But it was a sacred task, and not to be slighted. Patients always watched with interest while it was being done. And the fact that a nurse got quite a lift, or inspiration, from turning out a tight, neat bed quickly and efficiently is not to be ignored.

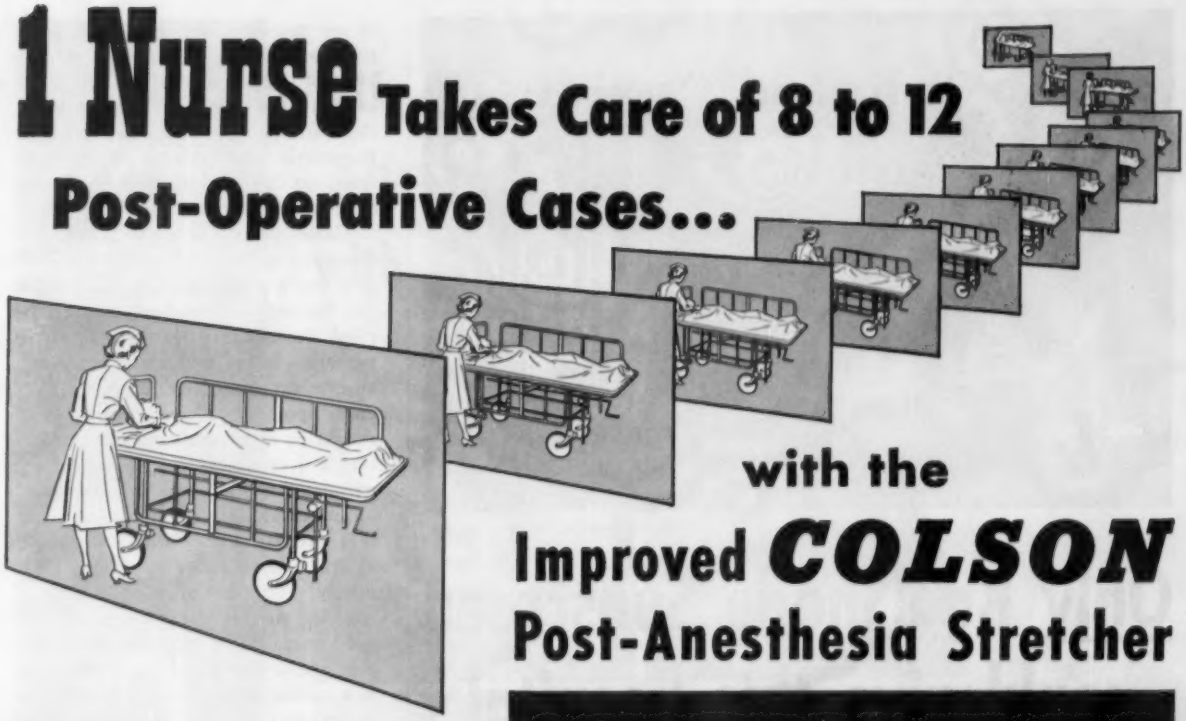
Yet when one can observe from day to day the smooth functioning of the new setup, it is hard to believe that anyone would tolerate having a person supposedly educated to care for patients stealing time from them to wash furniture and set up empty units.

SHE TRUSTS THEM NOW

When one is at the core of a teaching program, it is very easy to become discouraged and feel that nothing is being accomplished. Maybe that is one of the reasons it is so nice to have housekeeping maids around who know what to do and how to do it. You see, I didn't think we could trust them to do it right, and I'm sure this was the thought of many nurses. But, surprisingly enough, the housekeeping department can now make beds and set up units just as well as those in the nursing department ever did. This is the result of a successful teaching program, which is an inspiration in itself.

Our system, whereby, as discharges are written, the head nurse or her alternate places a list of rooms to be made up on the spindle and then the housekeeping supervisor takes over from there, is certainly smooth-running and effective. It is also heart-warming

1 Nurse Takes Care of 8 to 12 Post-Operative Cases...



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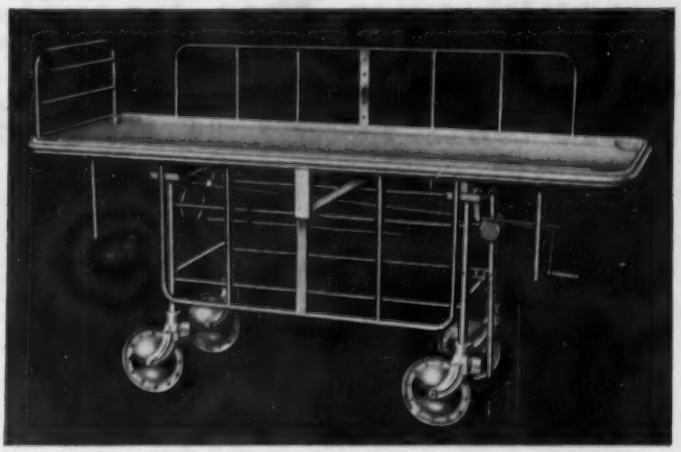

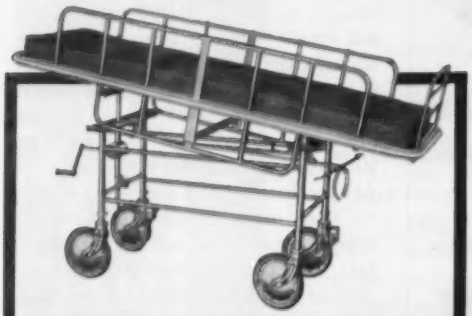

Colson model No. 6878 Post-Anesthesia Stretcher with litter raised to shock position. Elevating unit automatically locks in any position up to 20" elevation.

Now, with the COLSON post-anesthesia stretcher, one nurse can take care of 8 to 12 post-operative patients—a substantial savings in time, money and skilled help.

The new model No. 6878 stretcher shown here is the latest thing in post-operative care. Made of sturdy arc-welded tubular construction it is equipped with every device for the patient's comfort and safety, including easy-rolling, positive-locking casters with conductive rubber tires.

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to see members of the housekeeping staff occupied in getting a certain piece of linen needed in an emergency instead of sending a nurse or ward clerk for it. Our dumb-waiters and pneumatic tube system also serve to speed up this delivery of linen during off-hours during the day.

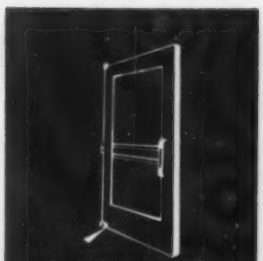
Those years of working blindly, when the ogre in the laundry wouldn't give you a piece of linen you *needed* (or the one in Purchasing hadn't supplied the cloth to the laundry ogre, perhaps—in a nightmare situation, anyone can seem like an ogre), certainly point out clearly that there should be more workable communication and understanding among all departments in the hospital. Too many misunderstandings occur because there is a mystery about what the people in other departments are doing. Ultimately, everyone in the hospital is working so that the patient will get good care. The fact that it is emphasized so strongly that housekeeping is a *service* department is one of the things that we feel is an especially strong point of the teaching program for housekeeping aides.

STUDENTS LEARN ABOUT LAUNDRY

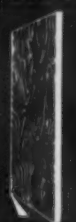
The course in nursing arts includes a one-hour lecture by the executive housekeeper. A few weeks later and just prior to the time the professional student nurses are placed in the clinical areas, they are taken on a conducted tour through the laundry. This is an effort to build rapport between the two departments, from the ground up, so to speak. One believes that with knowledge comes understanding. At best nurses use a lot of linen. But we strive to teach our nurses to use what is needed and still not be wasteful. Certainly, seeing those mountains of soiled linen should make some kind of impression.

Nursing is highly cognizant of the fact that it is absolutely helpless without the laundry. All patient comfort stems from having him, first of all, clean and in a clean comfortable bed, in clean pleasant surroundings. Lacking these basic attributes, the success of any therapeutic measures would be doubtful.

I feel that we have progressed a long way (or at least I have) when we can safely say, as we teach nursing: "No reasonable request is refused, if we call housekeeping or the laundry." Therefore, if in doubt, "Call Housekeeping."



entrance and vestibule doors

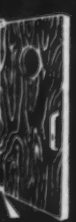


patient room doors

utility and supply room doors

operating room doors

x-ray room doors



toilet room doors

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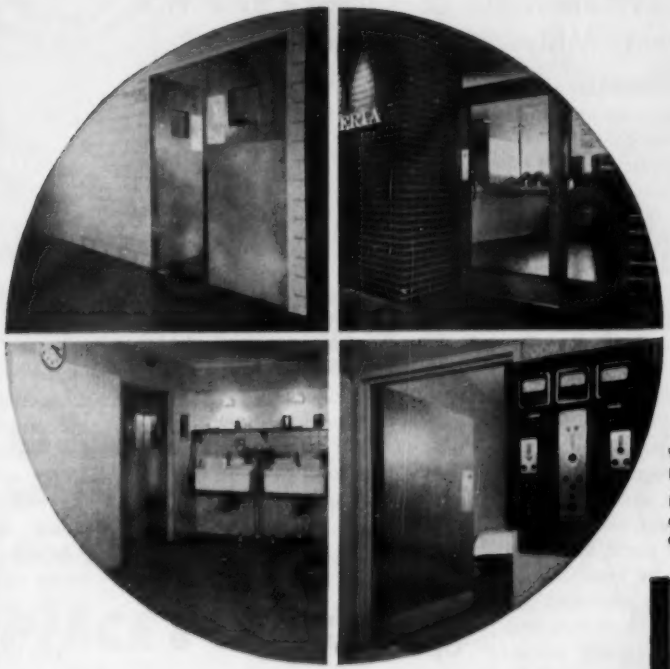

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NEWS DIGEST

Dr. Crosby Reports on A.H.A. Building Project at Midyear Meeting . . . Ruling Threatens Tax Exemption of California Hospitals . . . Elimination of Internship Suggested at A.M.A. Congress . . . Protestants Elect Dr. Frank Prentzel Jr.

Crosby Foresees Successful Completion of A.H.A. Building Project, Midyear Conference Told

CHICAGO.—Arrangements with Northwestern University for use of the land on which the new American Hospital Association headquarters building is to be built have been completed, Dr. Edwin L. Crosby, executive director, reported to the A.H.A.'s midyear conference of presidents and secretaries here last month.

The necessary appeal to the Chicago Zoning Board has been filed, Dr. Crosby added, and negotiations for financing construction have been undertaken. Successful completion of the project as planned depends now on the receipt of increased membership dues in accordance with estimates, Dr. Crosby said. It had been estimated, he explained, that there could be a possible loss of as much as 5 per cent in membership following the dues increase, but it seems unlikely now that any such loss will actually occur. Therefore, he concluded, success of the building project seems assured.

For much of the time during their two-day conference, the 200 hospital association officers attending the meeting were concerned about medical-hospital relationships. Summing up the position of hospitals today, Dr. Albert W. Snoke, chairman of the A.H.A. council on professional practice, said, "We have been counterpunching too long. We have spent our time putting out grass fires and battling on grounds chosen by the opposition." State and local hospital groups must make every effort to come to friendly agreement with medical societies, Dr. Snoke added. Above all, he said, hospitals must try to see that laws are written and interpreted so as to guarantee the best interests of hospital patients.

The conference also heard:

1. A report of the legal and legislative situation in Iowa, where hospitals had just filed suit against the State Board of Medical Examiners and state pathologists' association (see *p.* 62). The report was presented by Donald W. Cordes, administrator of Iowa Methodist Hospital, Des Moines.

2. A report by Andrew Pattullo, president of the Michigan Hospital Association, who discussed results of the recent Michigan Supreme Court decision restraining the Grand View Hospital of Ironwood, Mich., from excluding Dr. Samuel Albert from its staff. Mr. Pattullo said the state hospital asssociation had initiated discussions with the state medical society and felt the society was sympathetic

(*Continued on Page* 193)

Indiana Senate Gets "Open Staff" Bill

INDIANAPOLIS.—A bill that would permit any physician, regardless of staff membership, access to and use of public supported hospitals has been introduced into the Indiana State Senate, it was reported here last month.

The bill, which has the backing of the American Legion, has been referred to the senate's public health committee, the Indiana Hospital Association reported.

"The bill is strongly opposed by the Indiana Hospital Association and the Indiana Medical Association," a hospital association announcement said. "Should the bill be reported out of committee, all hospital administrators and officials of allied organizations are urgently requested to contact their state senators and representatives asking that they vote against the measure. Should the bill become law, it will not only seriously affect the satisfactory care of patients in all hospitals throughout the state of Indiana, but it would be suicidal to hospitals."

University of Oregon Hospital Will Admit Nonindigent Patients

PORTLAND, ORE.—The state board of higher education reaffirmed its announced policy of admitting other than indigent cases to the University of Oregon Medical School Hospital, over objection of the Oregon Medical Society, it was reported here last month. The hospital is scheduled to open for patients Jan. 1, 1956.

The board also rejected a society proposal that an advisory council of society members be established in connection with the medical school and hospital operation.

Objecting to the plan for admission of nonindigent cases to the teaching hospital, the medical society said this policy "raises a grave question as to whether a teaching hospital operating under such a policy would be engaged in the unauthorized practice of medicine."

The board policy statement in reply to the medical society suggestions read in part as follows:

"Legal responsibility for the operation of a medical school should be vested in a single body. Divided authority and responsibility between two legal bodies would probably lead to conflict.

"There is no more reason for having an advisory committee to the medical school than to other professional schools of the state system, such as agriculture, architecture and law at the university, or any other professional school.

"The hospital committee has met with [the medical society]. Some of their policy suggestions are good and are under consideration now. We are running an educational institution, primarily for education of student doctors, and for the practicing doctors of the state, to keep them informed. It is also run as a public service, and that obligation must be remembered."

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Medical Educators Suggest Elimination of Internship, See House Doctors Paid by Staff

CHICAGO.—Ultimate disappearance of the internship as a separate step in medical education was foreseen by members of a panel on the future of internships during the 51st annual Congress on Medical Education and Licensure here last month.

Opening the panel discussion, Dr. Edward H. Leveroos, director of the division of hospitals and graduate education of the A.M.A.'s Council on Medical Education and Hospitals, suggested that the internship might readily be eliminated as a separate phase of medical education, since its functions had already been largely absorbed by the clinical clerkship, on the one hand, and residency training on the other.

Agreeing with Dr. Leveroos was Dr. Ford Hick of the University of Illinois College of Medicine, who argued that the internship, as it is conducted in many hospitals today, is not fulfilling a definitive educational function. Dr. Hicks suggested that hospitals should employ house officers to perform the service functions of interns; if necessary, he added, the salaries of these house officers should be paid by the medical staff.

Other speakers on the panel were less ready to abandon the internship, it developed. In the discussion which followed, however, representatives of the specialty boards, state medical examiners, medical schools, and general practice acknowledged that the important thing is not simply to preserve the internship as it has been known in past years, but to provide an opportunity for continued training for the medical graduate, whether he is headed for general practice or for further graduate education in one of the specialties.

Following the meeting, Dr. Leveroos said the Council on Medical Education and Hospitals was studying the report of the A.M.A.'s ad hoc committee on internships, which included the recommendation that hospitals failing to obtain one-fourth of their internship quotas for two successive years be dropped for internship approval. If the council approved this recommendation, Dr. Leveroos explained, it would be submitted to the A.M.A. House of Delegates in June for approval before becoming a part of the council's internship essentials.

In another program at the Congress on Medical Education, Dr. Douglas D. Vollan, assistant secretary of the council, said television for medical teaching had been developing "by leaps and bounds" during the last year. "Its potential as a medium for bringing new research developments to the practicing physician seems promising," Dr. Vollan said.

Another speaker in a symposium on medical television, Dr. David S. Ruhe of Kansas University Medical Center, described television as "a powerful extension of the teacher's arm." Through television, Dr. Ruhe explained, the medical teacher may have "larger and better audiences where small ones have been necessary, as in surgery, the laboratory, and clinical demonstrations."

During the congress, the General Electric Company described a new technic of magnifying the microscopic details of pathological tissue and pro-

(*Continued on Page* 198)

Chancery Court Upholds Mississippi Physician's Suit Against Hospital

JACKSON, MISS.—A physician's suit against a nonprofit community hospital which denied him use of hospital facilities may be appealed to the state supreme court, the Mississippi Hospital Association reported here last month.

The suit was brought by Dr. Henry M. Lee of West Point, Miss., against the Memorial Hospital Foundation, charging he was "summarily" denied use of the 50 bed Ivy Memorial Hospital, operated by the foundation. The chancery court in which the case was heard found for the physician and issued an injunction ordering the foundation to permit Dr. Lee to use its facilities, the association said.

Indicating the chancery court decision may be appealed, attorneys for the foundation said that under the rules, by-laws and regulations of the hospital the medical staff is not required to state reasons for its recommendations to the hospital board, which had acted on staff recommendation in the case of Dr. Lee.

Before the case is appealed, the hospital association reported, foundation attorneys were expecting to file a motion asking the chancery court to dissolve the injunction.

California Ruling Threatens Hospitals' Tax Exempt Status

SAN FRANCISCO.—California hospitals reimbursing their radiologists or pathologists on salary or percentage arrangements may be threatened with loss of tax exemption, James E. Ludlam, attorney for the California Hospital Association, warned here last month.

Mr. Ludlam's statement followed issuance of an opinion on January 25 by John H. Keith, chief of the state division of assessment standards, to the effect that welfare exemptions may be questioned unless radiology and pathology departments are operated on lease agreements.

"It appears from this opinion that any hospital which is paying its radiologist a substantial salary or has the radiologist or pathologist on a participating agreement which is not in the nature of a lease will risk losing its entire exemption," Mr. Ludlam said in a memorandum to Paul C. Elliott, California Hospital Association president, following a series of conferences with Mr. Keith.

"On the other hand, if the arrangement is one of lease the exemption will be preserved on all but the leased property, even though the hospital retains substantial control and participates on a percentage basis," Mr. Ludlam continued. "I do not necessarily agree with the opinion of the State Board of Equalization that a participation agreement is grounds for the denial of its entire exemption, but on the other hand, as a matter of precaution, it would appear the better part of valor to pay a tax on 5 or 10 per cent of the hospital property and clearly preserve the exemption on the rest, rather than run the risk of losing the entire exemption.

"At the request of your council on legislation a bill has been prepared and introduced at the legislature which will clarify this matter to the advantage of hospitals. However, it is doubtful if such a bill, even if passed, would save the tax liability for the year 1955-56, as the attorney general has in similar situations ruled that such a bill cannot be retroactive. There is also a question as to whether or not the legislature will pass the bill itself. In any event, the association's officers and council on legislation are doing everything possible to protect the best interests of hospitals."

American Protestant Hospital Association Draws 1600; Dr. Prentzel Is President-Elect

CHICAGO.—Dr. Frank Prentzel Jr., administrator of Methodist Hospital, Philadelphia, was named president-elect of the American Protestant Hospital Association at the 34th annual convention of the association here last month.

More than 1600 administrators, trustees and workers in church affiliated hospitals were registered for the two-day convention, it was reported. Of this number, the largest group, approximately 700, was affiliated with the National Association of Methodist Hospitals and Homes, it was explained.

Dr. Prentzel will succeed the Rev. Carl C. Rasche, administrator of Evangelical Deaconess Hospital, St. Louis, who became president during the meeting. Clarence E. Copeland, administrator of Missouri Baptist Hospital, St. Louis, was the retiring president.

The Rev. Frederic M. Norstad, director of chaplaincy services for the Lutheran Welfare Society of Minnesota, was elected president of the Association of Protestant Hospital Chaplains. More than 200 hospital chaplains attended the meetings of this group during the convention.

In an address to one of the general sessions of the A.P.H.A., Ollie A. Randall, consultant on services for the aged, Community Service Society, New York City, discussed the needs of the aged, both well and ill, and the relationships among the general hospital, nursing home, and home for the aged. When an elderly patient is admitted to a general hospital for care of an acute illness or injury, Miss Randall said, plans must be made immediately for the kind of care required following the acute episode. Homes for the aged must refer to general hospitals only patients really needing acute care, she warned, and, at the same time, the homes must agree to take their residents back as soon as physicians indicate acute care is no longer needed.

The function of the nursing home is to bridge the gap between the acute hospital and the home for the aged, Miss Randall said. She doubted whether it was appropriate for the nursing home to be affiliated with or operated by either the general hospital or home for the aged, as some authorities have suggested.

Highlights of the group meetings and discussions follow:

EPISCOPALIAN

The conference of the Episcopal Hospital Assembly featured discussions on care of the aged and treating the patient rather than the disease. The Rev. Frederick A. Springborn, chaplain of the Norton Memorial Infirmary, Louisville, Ky., took office as president of the Episcopal Assembly.

LUTHERAN

Meetings of the Lutheran Hospital Association stressed chaplaincy service in the hospital and, especially, the difference between visitation and real counseling service. One entire discussion was devoted to financing hospital care, with attention to third-party payments and government assistance programs. The Rev. Carl R. Plack, director of chaplaincy service for the National Lutheran Council, Washington, D.C., was elected permanent secretary-treasurer of the Lutheran Hospital Association. (*Continued on Page* 170)

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EVANGELICAL

The Commission on Benevolent Institutions of the Evangelical and Reformed Church endorsed the standards of the Joint Commission on Accreditation of Hospitals and pledged its member institutions to an effort to meet accreditation standards. The Rev. Carl J. Scherzer, chaplain of the Protestant Deaconess Hospital, Evansville, Ind., was named president-elect of the commission.

MENNONITE

Care of aged patients was the concern of the Association of Mennonite Hospitals and Homes. The association also heard talks on hospital financing and personnel programs. H. Ernest Bennett, secretary for charitable institutions of the Mennonite Board of Missions and Charities, Elkhart, Ind., was elected president of the group.

BAPTIST

The meeting of the Southwide Baptist Hospital Association featured a report on hospital visitors by Clyde L. Sibley, administrator of the Baptist Hospital, Birmingham, Ala. Mr. Sibley described a comprehensive program for control of visitor traffic and behavior but acknowledged there were some visitors who ignored all efforts to regulate visiting practices. "There is no immediate solution to this problem," he concluded. "It is going to be a long, drawn out process of educating the public and the patients. The public may eventually learn to visit sensibly and intelligently, but the problem visitor will always be with us."

The American Baptist hospital group voted to hold a workshop in the summer of 1955 for executives of its hospitals and homes for the aged.

SALVATION ARMY

Discussions of the Salvation Army hospitals stressed the need for establishing hospital rates on a cost basis. Discussions covered changing trends in home and hospital service, case work, medical programs in small hospitals, and services for chronic and convalescent patients. The meeting was featured by the attendance of Commissioner Donald McMillan, national commander of the Salvation Army.

PRESBYTERIAN

Relationship between the hospital administration and chaplain was the

subject of a round table discussion conducted for administrators and chaplains of Presbyterian hospitals. Dr. Karl S. Klicka, director of Presbyterian Hospital, Chicago, was moderator for the discussion.

A.P.H.A. OFFICERS

In addition to the Rev. Mr. Prentzel, other officers elected by the American Protestant Hospital Association were: first vice president, Hal Perrin, administrator of the Bishop Clarkson Memorial Hospital, Omaha, Neb.; second vice president, the Rev. Paul R. Hanson, administrator of Emanuel Hospital, Portland, Ore., and treasurer, Dr. L. B. Benson, administrator of Bethesda Hospital, St. Paul.

Stop "Viewing With Alarm," Dr. Mayo Tells Methodist Conferees

CHICAGO.—The Rev. C. A. Sweazy, administrator of the Methodist Home at Versailles, Ky., was named president-elect of the National Association of Methodist Hospitals and Homes at the association's annual convention here last month. The Rev. Mr. Sweazy will succeed the Rev. Clarence W. Tompkins, Fort Dodge, Iowa, who became president during the convention. J. M. Crews, administrator of the Methodist Hospital at Memphis, Tenn., was the retiring president.

Ralph M. Hueston, superintendent of Wesley Memorial Hospital, Chicago, was elected first vice president.

The development of voluntary hospitals independent of government financing or control has been the outstanding characteristic of our American hospital system and has been largely responsible for our high standards of service, Dr. Charles W. Mayo of Rochester, Minn., told a luncheon meeting of the Methodist group. However, the decline in endowments for hospitals makes it necessary to tell the public the facts about hospital costs, he added. Dr. Mayo urged hospitals not to apologize or mince words about costs, but to assert through constant improvement in quality that hospital care is worth whatever it costs.

We must stop "viewing with alarm" the remote threat of socialized medicine, Dr. Mayo declared, and use our energies instead to improve patient care in our hospitals and institutions.

Many problems in institutional care of the aged and handicapped are com-

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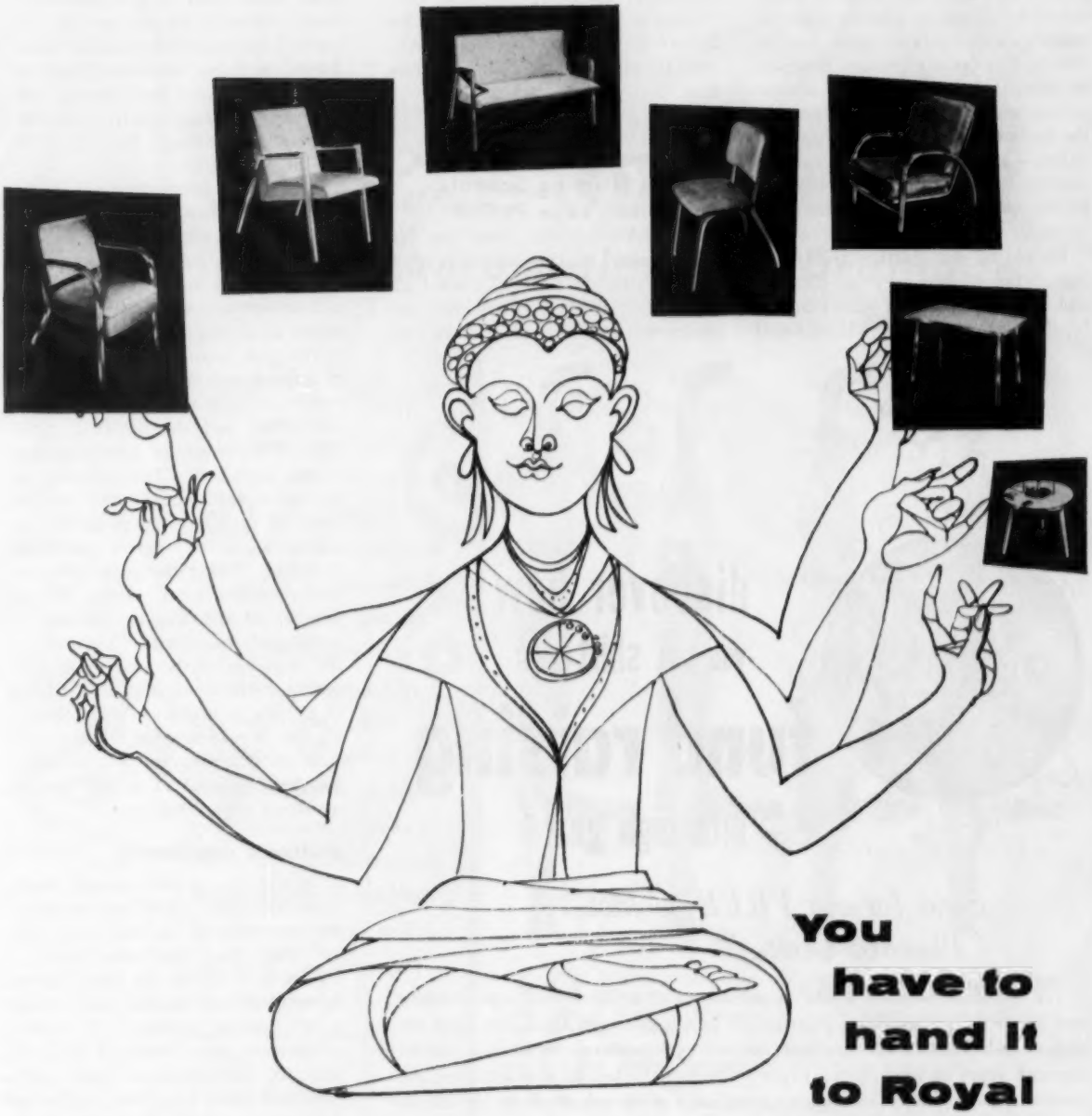
plicated by failure of these patients to use their energies and faculties to the full extent, and failure of institutions to encourage such use, Dr. Theodore G. Klumpp, chairman of the Hoover Commission's medical task force, said in another address to the association. Instead of abandoning the aged to a "rocking chair existence," Dr. Klumpp said, hospitals and homes for the aged must develop recreational, occupational and rehabilitation programs that will give aged patients an incentive to keep on learning. Science has shown such people quit learning not because of aging but because of lost incentive, he added.

An estimated 200,000 persons 65 years of age or older now in general or chronic disease hospitals could be rehabilitated and returned to a self-sufficient life in the community, Clark Tibbitts, chairman of the committee on aging and geriatrics in the federal Department of Health, Education and Welfare, declared. Too little attention has been paid to older people in the government's program for rehabilitating the handicapped, he added. Only one out of every 20 patients taking part in rehabilitation programs in 1954 was in the older age group, he said. Greater stress will be placed on aiding those in middle and later years of life in future development of the government's rehabilitation programs, Mr. Tibbitts concluded.

PRAISES TRUSTEES' CONTRIBUTION

The public generally fails to understand and appreciate the services of men and women who are contributing their time and energies as trustees of hospitals and homes for the aged, Raymond P. Sloan, president of the Modern Hospital Publishing Company, told the convention. "There are many who are not aware of the existence of the vast army of public-spirited men and women in this country who are contributing their time, their interest, and their money to others less fortunate," Mr. Sloan said. "I have even heard it intimated that these individuals receive financial recompense for their services. What compensation they receive cannot be measured by dollars and cents. In no other country in the world will you find such selfless devotion to the sick and suffering, to the young and old. It is in the American tradition."

Generally, trustees are motivated by the desire to help others and contribute to the common good, Mr. Sloan said.



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Ideally, he added, the hospital board should be chosen to provide a proper balance of occupations, ages and interests. The board's primary function, he concluded, is to select the administrator who is best qualified to provide the institution with the leadership it requires—"and, having done so, to permit him or her to assume responsibility for its operation without undue interference."

Elected to the "Methodist Hall of Fame" for philanthropy to hospitals and homes for the aged were Clarence N. Wesley, Evanston, Ill.; Edward Gallahue, Indianapolis; the Rev. Charles C. Jarrell, Oxford, Ga.; Dr. Robert A. Lambert, Greensboro, Ala., and Harold B. McKibbin, Wichita, Kan.

National League Extends Aid to Nursing Schools for Three-Year Period

NEW YORK.—Aid from the National League for Nursing to schools of nursing that are working toward improvement of their educational programs will be continued for three years under grants from the Commonwealth Fund, National Foundation for Infantile Paralysis, and Rockefeller Foundation, the league announced here last month. The grants have assured continuation of the temporary accreditation program through June 30, 1957, the league stated.

"During the intervening period, the N.L.N. on request will give one day of consultation without charge to nonaccredited and temporarily accredited basic programs in nursing education," said an announcement released by the league offices here.

The plan requires that each school of nursing seeking consultation must provide information about its resources, curriculum, and the particular problems on which special help is needed, it was explained. "The resulting information will provide data for the study of current practices in nursing education and the progress each school is making during the period of temporary accreditation," Helen Nahm, director of the league's division of nursing education, said. "Since one of the objectives of the program of temporary accreditation is to assist schools of nursing to strengthen themselves to a point of readiness for full accreditation, the new program of consultation has been planned to provide further assistance toward this goal."

STATEWIDE CONFERENCES

In addition to consultation service on an individual school basis, statewide conferences will be held each year following the consultants' visits to the schools within the state. School representatives, hospital and college administrators, members of advisory committees, state boards of nurse examiners, state and local league members, and other interested persons will have an opportunity to discuss various phases of nursing education—administration, costs, curriculum, faculty preparation, and others, Miss Nahm explained.

The program of temporary accreditation began in July 1951, as a means of helping schools of nursing in their efforts at self-improvement, she recalled. During the last three years schools of nursing have been assisted toward self-improvement through a variety of methods: consultation, full and temporary accreditation, regional conferences, preparation of self-evaluation guides, and other publications. These methods will be continued during the next three years, it is expected.

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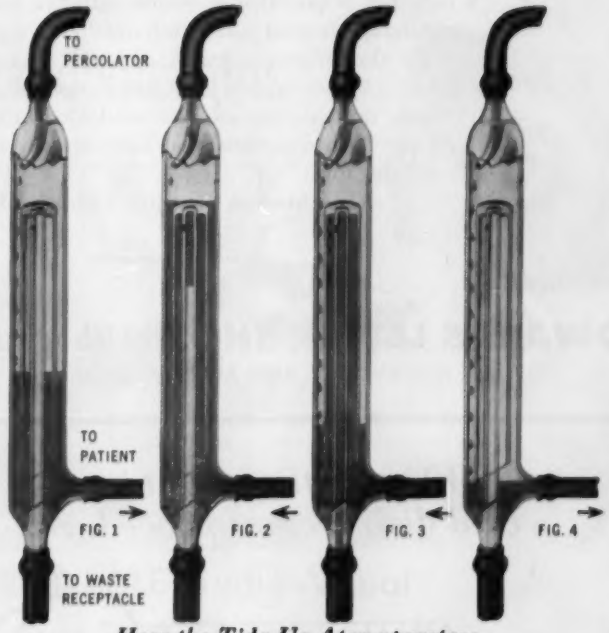

How the Tide-Ur-Ator operates:

Fig. 1 Irrigating fluid enters through tube at top, with rate of flow, in drops per minute, adjusted as desired. The side tube is connected to patient's catheter and permits irrigating fluid to enter the bladder. Lower tube leads to waste receptacle.

Fig. 2 The bladder has filled and the fluid in the Tide-Ur-Ator overflows into the syphon. As soon as this happens, the syphon action causes the flow through the side tube to reverse directions and drain the bladder.

Fig. 3 Both the bladder and Tide-Ur-Ator are nearly empty, and the direction of flow is still from the bladder, through the syphon, and into the discharge tube.

Fig. 4 The bladder is now empty, with the fluid level below the bottom of the outer tube of the syphon. This stops the syphon action and reverses the direction of flow through the side tube so that irrigating fluid again enters the bladder.

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Preventive Medicine Is Most Important, Darley Tells Medical Educators

CHICAGO.—Progress in preventive medicine is among the most important next steps to be taken in the whole medical field, Dr. Ward Darley, president of the University of Colorado, said here last month at a meeting sponsored by the National Fund for Medical Education. Dr. Darley predicted that eventually emphasis will shift "away from the patient on his back to the individual on his feet—from the patient in the hospital to the individual in his home and community."

Corporations with their thousands of employes are ideal "laboratories" to demonstrate the effectiveness of preventive medical measures, Dr. Darley said. "The staggering cost of absenteeism from work because of illness, and its concomitant in human misery and domestic dislocation, are well known," he said. "The answer lies in the maintenance of health and the prevention of ill health.

"The industrial or commercial concern employing large numbers of individuals should constitute the near perfect laboratory in which the effectiveness of preventive medicine can be demonstrated," he concluded. "Here is the cooperative situation in which health inventories, case finding programs, and programs of health education can take place."

New England Assembly Announces Program

BOSTON.—The New England Hospital Assembly meeting here March 28 to 30 will feature for the first time this year instructional conferences for hospital staff members in addition to the usual and special sessions, announced Richard T. Viguers, program chairman for the assembly. These conferences will deal with such topics as new laboratory technics, how to run a department head meeting, insurance, tissue committee, dietary, and "how to organize an administrator."

Leaders in the health, medical and hospital fields will speak on all phases of hospital work in the conference's 20 sessions, Mr. Viguers said.

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Dr. Stephen Manheimer Is Named President-Elect of Chicago Hospital Council


Dr. Stephen Manheimer

CHICAGO.—Dr. Stephen Manheimer, director of Mount Sinai Hospital, was elected president of the Chicago Hospital Council at the council's annual meeting here last month. Dr. Manheimer succeeded Dr. Morris Kreeger, director of Michael Reese Hospital. Arkell B. Cook, administrator of Evanston Hospital, Evanston, Ill., is the president-elect.

Naming hospital-physician relations as the primary concern of hospitals today, Dr. Kreeger in his annual report to the membership said he would not take issue with medical societies protesting against the employed status of specialists in hospitals. However, he added, if each specialist in the hospital were permitted to render a separate bill, the public would be confused and resentful.

James R. Gersonde, executive director, reported that 600,000 patients were treated in Chicago Area hospitals last year, at a cost of $150,000,000. There are 30,000 hospital beds in Cook County, Mr. Gersonde added, and 35,000 men and women on hospital payrolls.

C. Rufus Rorem, executive director of the Hospital Council of Philadelphia, addressed the Chicago meeting on the subject of community planning. He urged the necessity for long-term planning based on comprehension of community needs, with particular attention to development of outpatient departments, facilities for care of long-term patients, and interhospital cooperation. "Expansion of total bed facilities is not an unmixed blessing and is not always the most pressing need of a community," Mr. Rorem warned. "A hospital's own program and financial requirements cannot be predicted for more than a few years. But a new building affects professional policy for three or four decades, and commits future generations to finance the care received at the institution. An unnecessary building cannot be dismissed in the same way as one or more professional or institutional employes."

In addition to Dr. Manheimer and Mr. Cook, other officers elected by the council were: chairman of the board of directors, Stanley P. Farwell, trustee, Provident Hospital; secretary-treasurer, the Rev. Joseph A. George, administrator of Evangelical Hospital; directors: Charles J. Hassenauer, Msgr. John W. Barrett, Edison Dick, Leo M. Lyons, Dr. Manheimer and Mr. Farwell.

Gifts Increase in 1954

NEW YORK.—Philanthropy has climbed to new levels in the last year, a study released by John Price Jones Company, Inc., fund raising and public relations consultants, New York City, indicates.

Publicly announced giving in 10 cities in 1954 totaled $603,047,382, and in 1953 it was $495,039,966. These figures are for New York, Baltimore, Boston, Chicago, Houston, Los Angeles, Philadelphia, Pittsburgh, St. Louis and Washington. Gifts in these cities had increased to $473,045,413 from $401,060,586 the previous year; bequests totaled $130,001,969 in 1954, compared to $94,029,380 in 1953, the report indicated.

Student Nurse Enrollment Rises in 1954, Hayes Says

NEW YORK.—Students have been entering schools of nursing in ever increasing numbers, more in 1954 than in any year since World War II, according to John H. Hayes, chairman of the Committee on Careers of the National League for Nursing.

The larger enrollments Mr. Hayes attributes to the assistance given to the nursing careers program by American business and industry and also to the advertising and promotion which has publicized the nursing field in general.

Greater variety in educational programs within nursing which have emerged with the need for nurses with different types of preparation and improved working conditions in hospitals and health agencies have helped to make nursing more attractive as a career.

However, Mr. Hayes pointed out, the need for nurses is still greater than the number being graduated from accredited schools and this continues to be a problem in the nation's health.

10 Cincinnati Hospitals Launch Fund Campaign

CINCINNATI.—Big scale fund raising for 10 of the city's voluntary hospitals is to be centered in the Greater Cincinnati Hospital Funds, Inc., it has been announced by the Cincinnati Academy of Medicine, who has organized G.C.H.F.

The campaign goal has been set at $17,175,000, to be reached by July 1, 1956. During the 18 month campaign the canvass will first cover industrial and commercial interests in Cincinnati. It will then be extended to include every person in the Cincinnati area, the planning committee announced.

CORRECTION

In the tabular listing of consultation requirements of the Joint Commission on Accreditation of Hospitals appearing on page 166 of The MODERN HOSPITAL for February 1955, it was erroneously indicated that consultation is required on "all curettages." Item 2 under "Condition" should have been combined with item 3 to read: "All curettages or other procedures by which a known or suspected pregnancy may be interrupted." The commission points out that consultation is not required in case of curettage unless a known or suspected pregnancy may be interrupted by the procedure.

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IOWA HOSPITALS FILE SUIT FOR CLARIFICATION OF RIGHTS

(*Continued From Page 63*)
in the whole state of Iowa, Judge Herrick explained, and six of these practice in Des Moines. Thus technicians do the laboratory work in most of the state's 140 hospitals, he said—yet it is requested that this work should all be billed by the doctors.

Explaining another aspect of the case, Donald W. Cordes, administrator of Iowa Methodist Hospital, Des Moines, and chairman of the hospital association committee handling the dispute, said that enforcement of the attorney general's opinion would deny benefits to 200,000 Iowans covered by Blue Cross plans which pay for hospital services, but not by Blue Shield for medical services. Mr. Cordes quoted from letters he had received from several of the largest insurance companies in the country, in answer to inquiries about the status of their policyholders in Iowa under the attorney general's ruling:

"Under the circumstances, we have to consider that x-ray and laboratory services billed separately in the doctor's name would not constitute hospital service," said one of these letters. "Thus, generally, these would not be paid for at all under the terms of our hospital insurance coverages."

"It would be our practice not to allow for such charges if billed separately in the doctor's name," said another large insurance company. "Our policy reimburses the employe for hospital charges and services rendered by the hospital, but excludes physicians' fees."

One company, Mr. Cordes reported, did not positively exclude the possibility of payment for services billed by the physician. "We pay whether billed by the hospital or billed separately," this company's statement said. "However, under these circumstances we will not pay more than the usual hospital charges for such services. There is no doubt that it would be simpler for us to have all charges billed by the hospital."

While the attorney general was named among the defendants, Judge Herrick explained that the attorney general was a defendant in his official capacity only and was not a party to the alleged conspiracy. "The attorney general never intended his opinion to be used in this manner," he added.

Charging the State Board of Medical Examiners and pathologists' association and the presidents and secretaries of these organizations with conspiracy, the hospital petition said the purpose of the conspiracy was "to take away from the 140 charitable nonprofit hospitals in the state of Iowa the right to charge for the laboratory services the law requires such hospitals to furnish, and to place the right to charge for said laboratory services in the control of the members of said Iowa Association of Pathologists."

In furtherance of their illegal conspiracy, the petition charged, defend-

ants had "threatened various hospitals with the loss of pathological and radiological services unless said hospitals enter into written contracts with medical specialists giving them the right to make charges for all laboratory or x-ray services rendered and to bill for the same or require the hospital to bill for the same as the agent for said medical specialists."

The petition further charged the conspirators would "force said hospitals to turn over absolutely to said medical specialists the control of an integral part of their facilities which represents millions of dollars in buildings and equipment which have been supplied by private gifts and public appropriations and which have been entrusted by the public to the unpaid governing boards of said hospitals."

Shortly before the petition was filed, the Iowa State Medical Society had sponsored introduction of a bill in the state legislature aimed at preventing hospitals from receiving state or federal construction grants unless they agreed to medical society terms. The medical society bill would require the hospital, in order to qualify for aid, to "allow patients free selection of a licensed physician or licensed dentist of his own choice and shall not employ physicians or dentists on a salary, or restrict the patient to the use of any particular physician or physicians."

Hospital association attorneys felt the medical society bill would not receive favorable attention in the legislature; another bill, sponsored by the hospital association, would enable hospitals to receive state and federal aid under the extended Hill-Burton Act without adding any restrictions to present legislation, it was explained.

In addition to Judge Herrick and Mr. Cordes, those representing the hospital association at the press conference announcing the lawsuit were: Louis B. Blair, administrator of St. Luke's Hospital, Cedar Rapids, and president of the Iowa Hospital Association; Warner Byers, administrator of Graham Hospital, Keokuk; Thomas Murphy, chairman of the board of trustees, Murphy Memorial Hospital, Red Oak; Bruce Townsend, treasurer of the board of trustees, Jane Lamb Memorial Hospital, Clinton; Ralph L. Jester, chairman of the executive committee, Iowa Methodist Hospital, Des Moines, and Rev. F. J. Kaufmann, director of hospitals, Catholic archdiocese of Dubuque.

The 28 hospitals named as plaintiffs in the suit are: Mercy Hospital, Anamosa; St. Anthony Hospital, Carroll; Mercy Hospital, Cedar Rapids; St. Luke's Methodist Hospital, Cedar Rapids; St. Joseph's Mercy Hospital, Centerville; Jane Lamb Memorial Hospital, Clinton; Rosary Hospital, Corning; Jennie Edmundson Memorial Hospital, Council Bluffs; Mercy Hospital, Council Bluffs; Crawford County Memorial Hospital, Denison; Iowa Lutheran Hospital, Des Moines; Iowa Methodist Hospital, Des Moines; Mercy Hospital, Des Moines; Finley Hospital, Dubuque; St. Francis Hospital, Grinnell; Guthrie County Hospital, Guthrie Center; Mercy Hospital, Iowa City; Ellsworth Municipal Hospital, Iowa Falls; Evangelical Hospital, Marshalltown; St. Thomas Mercy Hospital, Marshalltown; Muscatine County Hospital, Muscatine; Mercy Hospital, Oelwein; Mitchell County Memorial Hospital, Osage; Mahaska County Hospital, Oskaloosa; Ottumwa Hospital, Ottumwa; St. Joseph Hospital, Ottumwa; Murphy Memorial Hospital, Red Oak, and Hand Memorial Community Hospital, Shenandoah.

Hawaii Medical Group Invites Kaiser to Keep Medical Care Plan Out

HONOLULU, T.H.—The Hawaii Medical Association has invited Henry J. Kaiser not to introduce his package plan for medical care in the Territory of Hawaii, according to an exchange of letters published in the *Honolulu Advertiser* here last month.

The medical society letter to Mr. Kaiser, reportedly, was prompted by newspaper stories indicating the Kaiser plan would be introduced in Hawaii if there was a demand for it on the part of doctors.

"We realize your plan has brought needed medical and hospital service to many areas where such service was lacking," said the statement reportedly signed by delegates of the Hawaiian medical association. "We can only commend you for such splendid service. However, in Hawaii, we already have built more hospital beds than are needed. Also, during the past 17 years, the doctors have gotten together and developed an insurance plan to spread the cost of sickness over a large number of people.

"A doctors' committee has been working for a long time in developing a more comprehensive plan for the community, and you no doubt have read in the papers recently about this new plan. The medical profession as a whole is proud of their accomplishments and is doubly proud that such a plan will permit any doctor in the territory the right to participate.

"We, therefore, as delegates assembled and representing all the doctors of the Hawaiian Islands, wish to inform you that we appeal to your sense of fairness not to introduce a plan that has caused so much ill-will among doctors in the communities where it has been established. It is not needed here, and we do not believe it will improve medical service in Hawaii.

"Those doctors who have told you they want you to come in are not speaking for the medical association and are a small minority."

According to the newspaper account, Mr. Kaiser replied: "I do not want to become a judge of local medical services. The doctors and the people are best qualified to determine that. First, the doctors can determine the services they want to give. Second, the people can determine the service they need and require."

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Army Using Too Many Doctors, Report Reveals

WASHINGTON, D.C.—About three times as many doctors as are needed in peacetime are being used by the armed forces, the government's Health Resources Advisory Committee reported last month.

According to the report, the army is using 3.3 doctors per 1000 troops, the navy, 3.7, and the air force, 3.2. One physician per 1000 troops, the committee believes, would provide liberal medical service to young men in military service, except under combat conditions.

These young men actually need less medical attention than any other population group, the committee said. Hospitalizing cases that would not be hospitalized in civilian life and keeping cases hospitalized for longer periods of time account in part for the greater number of physicians being used, the committee stated. Medical care is also given to dependents of military personnel, although it is estimated that at the present time military physicians spend only about 10 to 12 per cent of their time rendering care to members of servicemen's families.

St. Louis Administrator Sues Peoples Hospital

ST. LOUIS.—Alleging he was discharged from his position as administrator of Peoples Hospital here "without notice as required by the rules and regulations of the hospital," Elmer V. Mosee last month filed suit in circuit court against the hospital association and its board of directors, asking a judgment of $8166.62.

Mr. Mosee was discharged as hospital administrator last June, shortly after a hospital association election which he said was conducted improperly.

According to the petition, Mr. Mosee charged the defendant hospital directors "discharged the plaintiff without notice as required by the rules and regulations of said hospital; that the defendants did not give the plaintiff prior written notice of the cause of his removal; that the defendants did not give the plaintiff an opportunity to be heard prior to his discharge; that said discharge of the plaintiff by the defendants was wrongful and unlawful, and in violation of his contract of employment."

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Architects for Centinela Valley Community Hospital addition were Walker, Kalionzes & Klingerman, Los Angeles, California.

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Crosby Reports Progress on A.H.A. Building Plans

(*Continued From Page* 164)

to the hospital situation. Hospital association counsel was working on an amendment to the state law under which Dr. Albert's suit was brought, Mr. Pattullo reported, and the county hospitals affected by the court's decision were meeting to determine the proper course of action.

3. Another report on the situation in Colorado, where the hospital association is considering an effort to go to the legislature with suggestions for changes in the state medical practice act.

4. A report on the satisfactory doctor-hospital relationship in Massachusetts, where the hospital association and state medical society have agreed on a joint statement of principles and policies governing medical staff-hospital relations.

5. A report from Fred W. Moore, president-elect of the California Hospital Association, indicating that the chief of the state division of assessment standards had recently issued an opinion that hospitals do not meet requirements for tax exemption when their radiologists or pathologists are paid on a salary or percentage arrangement (see *p.* 166).

In a discussion of hospital nursing service, Dr. Hugo Hullerman of the United Hospital Fund, New York City, urged widespread support of training programs for nurse's aides. Dr. Hullerman said research projects had indicated that nurse's aides could perform a large percentage of the duties ordinarily assigned to practical nurses; some authorities believe the demand for practical nurses for hospital duty will diminish as a result of nurse's aide training programs, the speaker added.

In further discussion of training programs for nurse's aides, Robert S. Hoyt, administrator of the Lutheran Hospital at Baltimore and president of the Maryland Hospital Association, said that graduate nurses responsible for training nurse's aides often lack proper knowledge and preparation for this important teaching responsibility. He suggested that the development of standards for nurse's aide training should have top priority as a state hospital association program. "Time and money spent on such a project will pay off handsomely in better patient care and more efficient use of all nursing department personnel," Mr. Hoyt concluded.

In Pennsylvania, the state labor relations board ruled recently that nonprofit hospitals were exempt from state labor laws, Robert W. Gloman, president of the Pennsylvania Hospital Association, reported to the group. The state nurses' association had filed a complaint against a community hospital in the state, charging unfair labor practice, he reported. The labor relations board ruling came after briefs had been filed by both sides and several hearings had been held.

Solution of the enrollment and utilization problems of Blue Cross lies almost entirely in the hands of participating hospitals in Blue Cross plans, William S. McNary, director of Michigan Hospital Service and an A.H.A. trustee, told the conference. He also asked for hospital support in refuting false statements about Blue Cross being circulated by commercial insurance competitors. Reports that Blue Cross is "slipping" or "losing union support" are false and should be answered with the facts of Blue Cross enrollment, Mr. McNary declared.

Alabama Names Officers

BIRMINGHAM, ALA.—Douglas Goode, Jackson Hospital, Montgomery, was named president-elect of the Alabama Hospital Association at its recent annual convention. He succeeds John L. Howell, who was installed as president. Vice president is L. C. Rigsby, Cullman Hospital, Cullman, and secretary-treasurer, Murphy Cole, Anniston Memorial Hospital, Anniston.

Speakers at the Alabama meeting included (l. to r.): Dr. Harry Nevil, Dr. Frank S. Groner, and Dr. Minnie C. Miles. At right is G. C. Long Jr., who is the new executive secretary of the Alabama Hospital Association.

Frank Bynum, Gibson Hospital, Enterprise, and Will Stewart, Lee County Hospital, Opelika, were elected to the association's board of trustees.

V.A. Lacks Space for Mental Cases — Higley

WASHINGTON, D.C. — Shortage of facilities in mental hospitals is preventing 16,000 veterans from obtaining treatment in Veterans Administration hospitals, Harvey V. Higley, administrator of Veterans Affairs, stated in a recent broadcast of the CBS radio program, "Capitol Cloakroom."

At present there are 55,000 veterans receiving psychiatric care in hospitals maintained by the V.A. Facilities for 3000 more patients are to be added soon, but, Mr. Higley said, that spells the end of the hospital construction program "except for possible replacements of hospitals that are in bad shape."

The real shortage, he continued, lies in trained personnel, psychiatrists, psychologists and therapists. Since the inadequate number of specialists is a general one, affecting nonveterans as well as veterans, Mr. Higley said, the Veterans Administration "simply cannot expect more than our share of those available."

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Hospitals Reply to Editorial Criticizing Them for Aloofness

BOSTON. — A newspaper editorial charging hospitals with aloofness and claiming "the average hospital today needs a lot of humanizing" drew sharp retorts from hospital administrators and the public here last month.

Dr. Warren F. Cook, consultant to the New England Deaconess Hospital, said the editorial was "negative" and indicated most patients found the hospital kindly and homelike.

In another reply to the editorial, Ernest P. Staples, president of the board of trustees of Union Hospital, Lynn, Mass., said it cast "unjust and unwarranted aspersions on the large majority of hospitals operating in and around this area."

Entitled "Humanizing the Hospital," the *Boston Herald* editorial said the hospital serves the community—"but serves it from outside. It comes from time to time to the rest of us to state its financial needs, and then it retires again into its impersonal professional shell, disdainful of the contacts that make other institutions of society seem real and alive.

"Too often, the medical profession and hospital administrations have confused dignity with silence. They have been so afraid of publicity or the gibe of 'advertising' that they have taken themselves quite out of the stream of contemporary existence.

"It seems both fair and wise that we who support the hospitals should share also in their day-by-day existence, that we should feel a sense of common purpose with them. We can't if they are aloof."

Taking exception to this view, Mr. Staples said hospitals, "instead of being bleak, remote and aloof, are for the most part an integral part of the community, operated by groups of public minded, nonpaid citizens, supported by local contributions and aided by hundreds of volunteer workers who cheerfully give hours of time to hospital service."

In connection with an implication in the editorial that hospitals were unwilling to give out information that might have news value, Mr. Staples said: "It should be borne in mind that the first interest of the hospital lies in the patient. The relationship between the hospital and patient may be as intimate and as personal as any that you will find. Just as matters between a doctor and his patient or a lawyer and his client must always be held in strictest confidence, so must the hospital keep inviolate its relationship with the patient. You may be sure, however, that any hospital will gladly welcome any news story regarding public policy and matters of an informative nature about the services it renders to the public."

Suggests Plan for Regionalization of Medical Facilities

NEW YORK.—A plan to regionalize medical facilities throughout the United States has been proposed as a partial answer to the problem of continuous postgraduate education, according to the *Journal of Medical Education*. In an article that appeared in the February issue of the *Journal*, Dr. John B. Grant of the Rockefeller Foundation's division of medical and public health described a plan in which independent hospitals in a given area are to be integrated to seem like one giant hospital. Distant branches would be related to each other as if they were wards or divisions of a large medical center. In this way it would be possible to develop in the community hospital an approximation to the teaching hospital, he explained.

Regionalization would make diagnostic facilities available to small communities; this would attract board certified physicians whose presence would make accreditation for intern-residency training possible. More adequate record and library facilities and the establishment of central pathological and staff conferences, and ward rounds would also be possible, according to Dr. Grant.

To finance such a plan funds of two kinds are needed, Dr. Grant stated: grants-in-aid for diagnostic and training facilities at district and rural levels until the programs could be financed by the community, and extramural funds so that base and district hospitals may extend their responsibility to the community.

Financial sources would include dues from hospital members, grants from the community chest, Blue Cross, earnings from services performed, and terminating grants from foundations.

Dr. Grant stated that tentative figures for permanent cost in two of the plans is 15 and 10 cents per year per person.

Congress on Medical Education and Licensure

(*Continued From Page 166*)

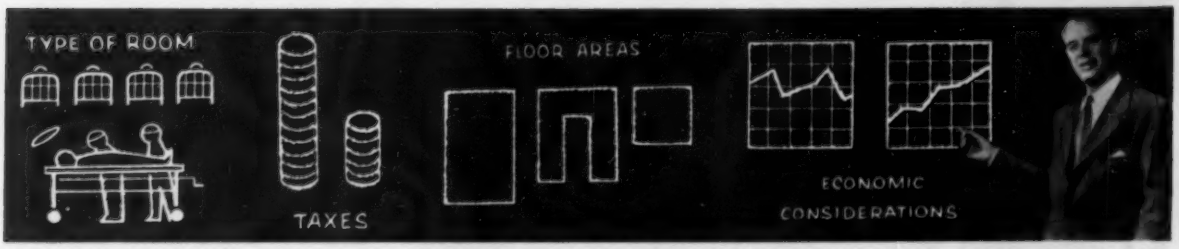
jecting their images, in full color, onto a 6 foot screen. The system featured use of closed circuit color television, it was explained, and can magnify a microscopic specimen up to 15,000 times. A company representative said the combination of closed circuit color television and microscopy offered a new tool for medical education.

"The system can be used for teaching large medical audiences in the classroom and at great distances," he declared. "The diagnostic abilities of leading pathologists also would be available to all sections of the country when needed rapidly, or for instruction. In the surgical hospital, rapid consultations via closed circuit TV microscope can take place between the operating surgeon and the pathologist while the operation is being performed. In hospitals too small for a resident pathologist, the full color image of the specimen could be transmitted via the TV-microscope system to a pathologist in a hospital several miles away. The diagnosis would then be immediately available while the operation was in progress."

Medical schools, rather than hospitals, should provide the supplementary education needed by immigrant doctors if they are to be useful in practice and in the armed forces, Dr. Robert Boggs, dean of the postgraduate medical school of New York University, told the congress. Reporting results of a program which provides a year of education for immigrant doctors, Dr. Boggs said 71 physicians had completed the course successfully, and 60 had passed state board examinations. Graduates of the program are now practicing in one or another of the 10 states which accept their credentials, he added.

While some of these immigrant physicians came from inferior medical schools, Dr. Boggs said, with the additional year of training "they compare favorably in the practice of medicine with graduates of approved American schools."

Under a plan approved by the Federation of State Medical Boards during the congress, foreign trained doctors would be required to take examinations in the basic medical sciences and major clinical departments before they could practice in the United States.



Many, many factors influence the choice of a hospital's air conditioning system. Heat loads and glass areas and number of patients and floor areas . . . economic considerations, taxes, depreciation and operating costs are some of them. And because these factors (and still others) vary from hospital to hospital, across the land, it becomes obvious that no one system—or even two or three—can air condition each hospital best. That's why York carefully selects and precision-engineers each Yorkaire System to fit the particular hospital in which it is installed.

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COMING EVENTS

AMERICAN ASSOCIATION OF INDUSTRIAL NURSES, Annual Conference, Memorial Auditorium, Buffalo, N.Y., April 25-29.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, LaSalle Hotel, Chicago, Oct. 3-7.

AMERICAN HOSPITAL ASSOCIATION, Traymore Hotel, Atlantic City, Sept. 19-22.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Eastern Area Institute, Statler Hotel, New York, March 25, 26. Annual Meeting, Statler Hotel, Washington, D.C., Oct. 30-Nov. 2.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, April 25-28.

CANADIAN HOSPITAL ASSOCIATION, Biennial Meeting, Chateau Laurier Hotel, Ottawa, Ont., May 9-11.

CAROLINAS - VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 21, 22.

CATHOLIC HOSPITAL ASSOCIATION, Kiel Auditorium, St. Louis, May 16-19.

INTERNATIONAL HOSPITAL CONGRESS, Lucerne, Switzerland, May 30-June 3.

KENTUCKY HOSPITAL ASSOCIATION, Seelbach Hotel, Louisville, April 12-14.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Annual Conference, Shoreham Hotel, Washington, D.C., Nov. 7-9.

MASSACHUSETTS HOSPITAL ASSOCIATION, Annual Meeting, Hotel Statler, Boston, May 25.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 25-27.

MID-WEST HOSPITAL ASSOCIATION, President Hotel, Kansas City, Mo., April 27-29.

NATIONAL COUNCIL OF HOSPITAL AUXILIARIES OF CANADA, Biennial Meeting, Chateau Laurier, Ottawa, Ont., May 9-11.

NATIONAL HEALTH FORUM, Hotel Sheraton-Astor, New York, March 23, 24.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 28-30.

NEW MEXICO HOSPITAL ASSOCIATION, Annual Convention, Hilton Hotel, Albuquerque, March 24-26.

NEW YORK STATE ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Annual Meeting, Hotel Ten Eyck, Albany, May 4-6.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, March 7-10.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Spring Conference, Marvin-Hugitt Hotel, Huron, April 18, 19.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta Biltmore Hotel, Atlanta, Ga. April 20-22.

TENNESSEE HOSPITAL ASSOCIATION, Chattanooga, May 19-21.

TEXAS HOSPITAL ASSOCIATION, Hotel Shamrock, Houston, April 12-14.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-5.

UPPER MIDWEST HOSPITAL CONFERENCE, Nicollet Hotel, Minneapolis, May 11-13.

WASHINGTON STATE HOSPITAL ASSOCIATION, Mid-Year Meeting, Winthrop Hotel, Tacoma, March 30; Annual Meeting, Davenport Hotel, Spokane, Oct. 19, 20.

WISCONSIN STATE HOSPITAL ASSOCIATION, Milwaukee, March 17.

Wheel Chairs by Everest & Jennings,
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FOR YEARS
OF BEAUTY, COMFORT
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UPHOLSTERY
OF HANDSOME

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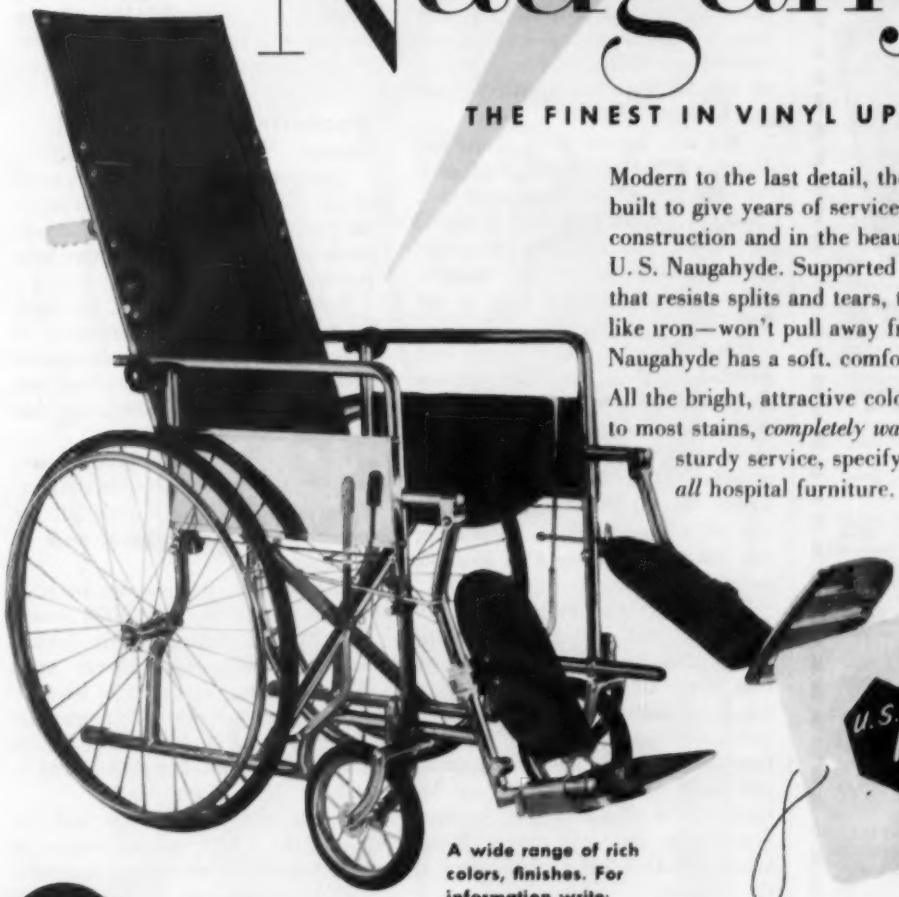
THE FINEST IN VINYL UPHOLSTERY



Modern to the last detail, these fine quality chairs are built to give years of service, in their all-metal construction and in the beautiful upholstery of U. S. Naugahyde. Supported by a strong fabric backing that resists splits and tears, this finest of vinyls wears like iron—won't pull away from fastenings. U. S. Naugahyde has a soft, comfortable finish.

All the bright, attractive colors are fade-free, resistant to most stains, *completely washable*. For sanitary, sturdy service, specify U. S. Naugahyde for *all* hospital furniture.

A wide range of rich colors, finishes. For information write:

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Announce Expansion of N.Y. Blood Assurance Plan, But Program Lacks Hospital Approval

NEW YORK.—Following successful completion of the pilot "Blood Assurance Program" in Genesee County last year (see The MODERN HOSPITAL, December 1954) the Blood Banks Association of New York State has extended the program throughout the New York metropolitan area, with the cooperation of the five county medical societies of New York City, it was announced here last month.

Ten hospitals in New York City have agreed to act as collection agencies, the association said, announcing that blood contributions would be accepted at these collection stations, and donors would be given credit entitling them and members of their immediate families to receive four free pints of blood at any time during the ensuing year.

However, the program has not been approved by the Greater New York Hospital Association, it was reported. John V. Connorton, director of the hospital association, said he knew of no hospital that had agreed to take part.

"We have agreed to sit down and discuss a blood assurance program in the near future," Mr. Connorton said. "Hospital people feel that it should be worked out with representatives from the hospitals, medical societies, and community groups, such as the Red Cross."

Subscribers to the program and members of their immediate families are protected anywhere in the state or nation, the Blood Banks Association's announcement had said. Under the program, it was explained, the subscriber would still have to pay the cost of administering a transfusion; this cost might average $5 a pint, the association said.

The New York Blood Banks Association program was described as the first large-scale application of the new plan in the United States. It is sponsored by the five county medical societies of New York City, in cooperation with the Blood Banks Association and the New York State Medical Society, it was explained. Dr. Solomon Schussheim, president of the Kings County Medical Society, is director of the program.

"The new program is expected to increase by 30 to 50 per cent the number of volunteer blood donors in the New York area," the association stated. More than 14,000 physicians in the metropolitan area are scheduled to contribute their own blood within the next two or three weeks, to "get the program rolling," it was announced.

"The Blood Assurance Program will not compete or interfere with essential blood procurement work being done by the Red Cross and other nonprofit blood collection agencies," Dr. Schussheim stated. "But we physicians, who know what goes on behind the scenes when our patients require blood transfusions, are daily being made painfully aware of the fact that our hospital blood banks are drying up.

"No individual or group or organization will realize one cent of profit from the blood collected in this program. Furthermore, the Blood Banks Association itself owns no blood banks, owns no blood, collects no blood, and sells no blood. It is simply providing a service to the people of this city through the financial support of the medical profession."

Discontinue A.M.A. Seal; Cause: "Too Little Time"

CHICAGO.—The seal of acceptance of the American Medical Association has been discontinued, it was announced at A.M.A. headquarters here last month.

For many years, the seal was used by manufacturers and distributors of drugs, foods, cosmetics and therapeutic devices to indicate their products had been evaluated and found acceptable by A.M.A. councils.

However, the A.M.A. said, the seal program had become so time consuming there was too little time left for attention to other important work of the councils.

"As of now, the issuance of seals or emblems by any part of the American Medical Association is discontinued," the announcement said. "Obviously, the seals may be seen for some time, as advertising material already printed is used. But it is only a matter of time before an A.M.A. seal is a thing of the past."

While the familiar seal will be absent, the A.M.A. assured readers of its *Journal* that advertising standards will be maintained as before. The need for the seal diminished as manufacturers assumed responsibility for marketing worth-while products, it was explained.

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are the choice of

leading hotels, hospitals, restaurants and institutions everywhere

5000 lb. *and* 2000 lb.

Capacity package Units

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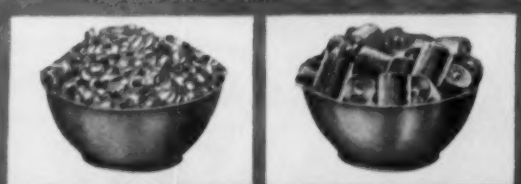

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Clear, hard, Tube-Ice is quickly frozen from water circulating inside of tubes of small diameter and need never be touched by human hands. Either cylinder or crushed ice may be had from the same unit with the flick of a switch.

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75th Anniversary

A.M.A. Judicial Council Rules H.I.P. Doctor Did Not Violate Ethics

CHICAGO.—The Judicial Council of the American Medical Association ruled here last month that Dr. Ben E. Landess, Queens County, New York, physician, did not violate medical ethics in his affiliation with New York's Health Insurance Plan as charged by the Queens County Medical Society last year.

Dr. Landess had previously appealed his case to the house of delegates of the New York State Medical Society, which upheld the Queens County decision charging violation.

Expressing a contrary opinion, the A.M.A. Judicial Council said: "Since H.I.P. is organized and operates in accordance with law and may lawfully advertise; since the quality of its advertising is not an issue, and since Dr. Landess had nothing to do with the preparation or distribution of the advertising, it is our opinion, contrary to that of the state and county medical societies, that the conduct of Dr. Landess does not violate the ethics relating to solicitation and advertising."

Dr. Landess was a member of the Jamaica Medical Group, affiliated with H.I.P. Group advertising, it had been charged, involved a violation of the Principles of Ethics on the part of Dr. Landess, who is medical director of the group. The case against Dr. Landess was first brought up by the Queens County society in 1951, when his name appeared in an H.I.P. brochure.

The decision was rendered after months of study of the evidence by the A.M.A. Judicial Council, it was reported here. The council described the Landess case as "one of the most heated and controversial ever to come before the Judicial Council."

The Judicial Council ruling said in part:

"It is important to note that the only question before the Judicial Council is whether Dr. Landess has violated the Principle of Medical Ethics of the A.M.A. pertaining to solicitation of patients by advertising. No charge of violation of any other ethic is made.

"The following appears to be the basis of the decision that Dr. Landess violated the ethic pertaining to advertising: The Queens County Medical Society found that H.I.P. advertised directly to the public and that by means of this advertising Dr. Landess 'directly benefits by the solicitation of patients . . . inasmuch as the H.I.P. solicits patients only for the groups of physicians which are contractually bound to it.'

"The action of the Queens County Medical Society does not deprive Dr. Landess of membership privileges at this time. The report specifically recommended that 'no action be taken against him,' and this report was adopted. The action was in reality an advisory opinion 'given for the information and guidance of the members of this society.'

"There is no charge or any finding that Dr. Landess had anything to do with the preparation or distribution of the advertising or promotional material nor is there anything in the testimony or exhibits to substantiate any such conclusion.

"We do not mean to imply by our decision in this appeal that a physician can ethically associate himself with an organization which is either unlawful or one which indulges in improper or unethical advertising, nor absolve himself from appropriate disciplinary action by complacence or indifference."

In the last paragraph of its decision the Council stated that an exhaustive study of medical care plans had been authorized by the A.M.A. board of trustees last December.

"The Judicial Council," the statement said, "is participating in this study which will include an analysis and review of the ethical and other problems arising out of the relationship between medical care plans, patients and physicians. The study referred to will include a thorough analysis of the H.I.P. type of organization, among others."

Announce Plans for Catholic Conference

ST. LOUIS.—The 40th annual convention of the Catholic Hospital Association will be held in St. Louis May 15 to May 19, it was announced at association headquarters here last month. The Rev. John J. Flanagan, executive director of the association, said there would be concurrent meetings of the Conference of Catholic Schools of Nursing and the Hospital Chaplains Conference.

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Guaranteed by Good Housekeeping

Bates NEW "COLONIAL" MATTRESS PAD

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Sizes 17 x 18, 26 x 34
12 dozen to carton, 1 dozen to package
Sizes 38 x 72, 38 x 76, 52 x 76
3 dozen to carton, ½ dozen to package

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ask your distributor

Bates POPULAR "NAPLITE" COTTON BLANKET

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WILL ROSS, INC.
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AMERICAN HOSPITAL SUPPLY CORP.
2020 Ridge Ave., Evanston
THE BURROWS CO.
325 Huron St., Chicago
CLARK LINEN & EQUIPMENT CO.
303 W. Monroe St., Chicago
FUERSTENBERG & CO.
21 Hubbard St. East, Chicago
HARRIS HOSPITAL SUPPLY, INC.
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CAROLINA ABSORBENT COTTON CO.
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1375 E. 21st St., Cleveland
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TAYLOR SYMONDS CO.
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SOUTH CAROLINA
QUALITY TEXTILES, INC.
301 Calvin St., Greenville

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THE ALAMO CO.
58 South Second St., Memphis
WM. R. MOORE DRY GOODS CO.
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RICE STIX, INC.
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PATRICK DRY GOODS CO.
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ABOUT PEOPLE

(*Continued From Page 88*)

William R. Morgan, former administrator of Kissimmee Hospital, Kissimmee, Fla., has been appointed administrator of Preston Memorial Hospital, now under construction at Kingwood, W.Va. Mr. Morgan recently received his master's degree in hospital administration from Northwestern University.

Oscar L. Modesto, administrator of Bangor City Hospital, Bangor, Maine, has become superintendent of Bessie M. Burke Memorial Hospital, Lawrence, Mass., succeeding **Frank B. Bingham,** who has been acting administrator for the past few months. Before coming to Bangor, Mr. Modesto had served as assistant administrator at Symmes Arlington Hospital, Arlington, Mass., and as supervisor and member of the faculty at Hartford Hospital, Hartford, Conn.

James M. Edwards, formerly business manager of Leeds Hospital, Inc., Leeds, Ala., is now director of Emanuel County Hospital, Swainsboro, Ga., succeeding **Maj. A. S. Walea,** who has retired. Mr. Edwards is a recent graduate in hospital administration from the University of Georgia.

Sister M. Zenona has become administrator of Villa Madonna Hospital, Enid, Okla. The hospital, which has been remodeled to care for chronic disease patients, was formerly known as St. Mary's Annex.

R. H. McKinnon, who has been administrator of Lee County Memorial Hospital, Bishopville, S.C., has been named administrator of Rutherford Hospital, Rutherfordton, N.C.

Justin W. de P. Green, assistant administrator of Emma L. Bixby Hospital, Adrian, Mich., has been appointed administrator of Williams County General Hospital, Montpelier, Ohio. Mr. Green received a diploma in hospital administration from the University of British Columbia.

Richard B. Anderson has assumed his duties as assistant administrator of Methodist Episcopal Hospital, Philadelphia.

Melba Cater, R.N., is now administrator of Waller County Hospital, Hempstead, Tex., succeeding **Norman Hardin,** who has resigned.

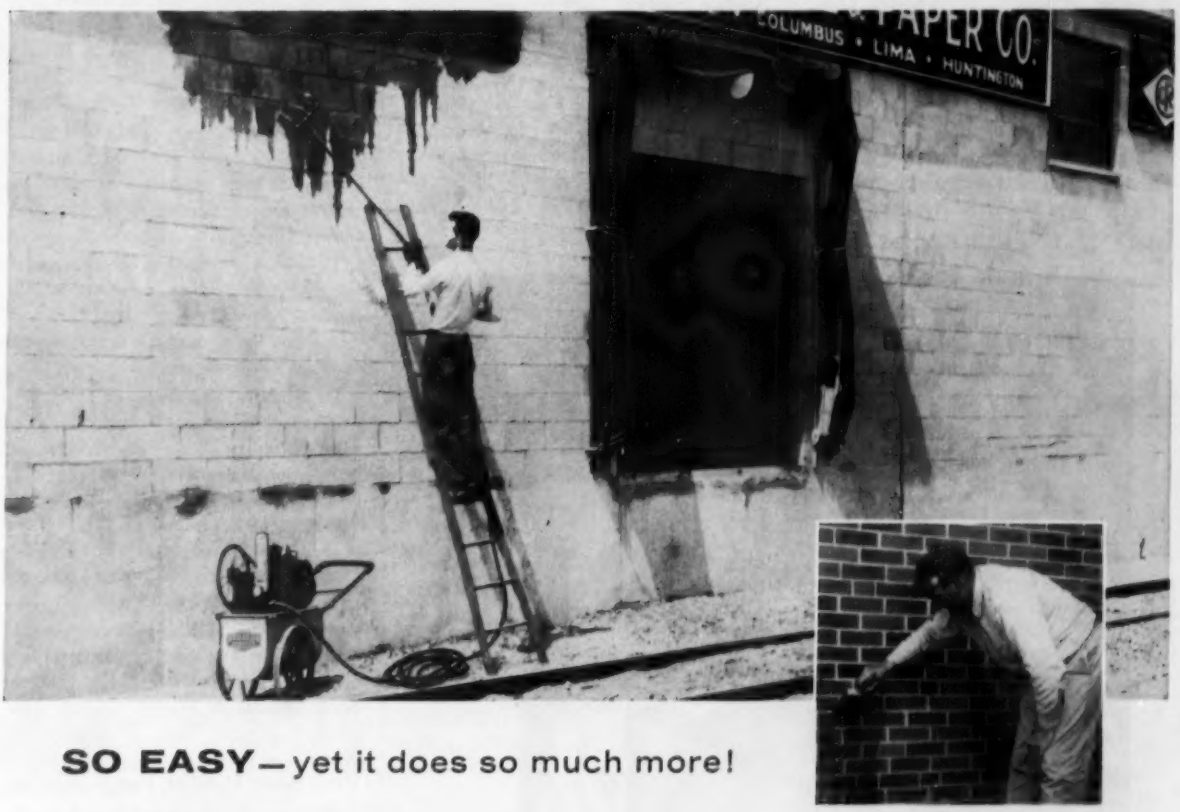
E. Guy Cutshall, D.D., is the new administrator of Inter-Mountain Deaconess Home for Children, Helena, Mont. The Rev. Mr. Cutshall has served as a university chaplain and as director of religious education. He has been president of West Virginia Wesleyan College, Buckhannon, and of Iliff School of Theology, Denver, as well as chancellor of Nebraska Wesleyan University, Lincoln.

Sister M. Salesia, who has been business manager of St. Mary's Mercy Hospital, Gary, Ind., for the last 13 years, is now administrator of St. Mary's Hospital, East St. Louis, Ill. She succeeds **Sister M. Edwina,** who has been stationed at the institution for 20 years. Sister Edwina has been transferred to St. Catherine's Hospital, East Chicago, Ind.

Rodney J. Lamb, administrative resident at Peninsula Hospital, Burlingame, Calif., has been appointed administrator of E. V. Cowell Memorial Hospital of the University of California, Berkeley. Mr. Lamb received his M.P.H. degree from the University of California.

Kenneth A. Rindflesh, assistant director of Denver General Hospital, Denver, has become director of Salt Lake County General Hospital, Salt

AN INVISIBLE RAINCOAT now protects this warehouse and office building. The above-grade masonry water repellents made with *Linde* Silicones apply easily by low-pressure spray or (inset) by brush.



SO EASY—yet it does so much more!

Just a low-pressure spray application—or simple flushing on with a brush.

That's all it takes to keep out water for many years to come—when you apply above-grade masonry water repellent made with *Linde* Silicones.

But it does so much more!

OUTSIDE

As soon as it dries it is colorless. It leaves no shine. It stops rain from penetrating even when driven on 100-mile-an-hour winds. Since it puts a water-shedding surface on masonry, concrete and brick, dirt washes right down to the ground.

It lines yet it does not seal up the pores, so moisture entrapped before treatment can evaporate. Thus spalling and cracking due to freezing are halted. Efflorescence, too, is prevented.

INSIDE

The benefits really multiply. Plaster, woodwork, paint and wallpaper stay dry. Peeling and staining due to moisture penetration are banished. Decorating, maintenance and repair costs drop.

See for yourself how easy and inexpensive it is to put a lasting, invisible raincoat on homes, institutions, schools, factories, churches, office buildings. Write today for full information and a list of representative suppliers. Address Dept. F-3.

FOR SILICONES LOOK TO

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Lake City, succeeding **Lloyd Hughes,** who has been serving as temporary administrator.

Marion F. Reager, assistant manager of the Veterans Administration Hospital, Seattle, has been named assistant manager of the V. A. hospital, Oakland, Calif.

Jean M. Oakes, who has been office manager of Chester County Hospital, West Chester, Pa., has been appointed assistant director there.

Bert W. Dickenson, formerly purchasing agent and pharmacy manager of Hendrick Memorial Hospital, Abilene, Tex., has become administrator of Gladewater Municipal Hospital, Gladewater, Tex.

George M. Brewer, administrator of Roosevelt General Hospital, Portales, N.M., has become administrator of Los Alamos Medical Center, Los Alamos, N.M. He is succeeded at Roosevelt by **Thomas J. Hartford Jr.,** who has served in the 171st Station Hospital in Korea and the 14th Field Hospital, Pusan, Korea. Mr. Brewer is a graduate of the University of Colorado and was formerly administrator of Hansford Hospital, Spearman, Tex. He is a past president of the New Mexico Hospital Association and a nominee of the American College of Hospital Administrators. He is a member of the board of directors of the New Mexico Blue Cross. A graduate of George Washington University, Mr. Hartford was formerly associated with Walter Reed Hospital, Washington, D.C.; Brooke Army Medical Center, Fort Sam Houston, Tex., and St. Louis Medical Depot.

John L. Sundberg, administrator of Caldwell Memorial Hospital, Caldwell, Idaho, has been appointed assistant administrator of Culver City Hospital, Culver City, Calif.

T. J. Walker, who has been personnel manager for the Texas division of the Dow Chemical Company, Freeport, Tex., has been named administrator of Dow Hospital, there.

Dr. Joseph C. Tatum, chief of professional services of Veterans Administration Hospital, Tuscaloosa, Ala., has been appointed manager of the V.A. hospital, American Lake, Wash. He succeeds **Dr. Thomas J. Hardgrove,** who is now manager of the new Veterans Administration Neuropsychiatric Hospital, Sepulveda, Calif.

Dudley R. Keith, former administrator of Sweetwater Municipal Hospital, Sweetwater, Tex., has become administrator of Hardin County Hospital, Kountze, Tex. Previously Mr. Keith had been purchasing agent of City-County Hospital, Fort Worth, Tex.

William E. Sheppard has been appointed assistant to the superintendent of Friends Hospital, Philadelphia.

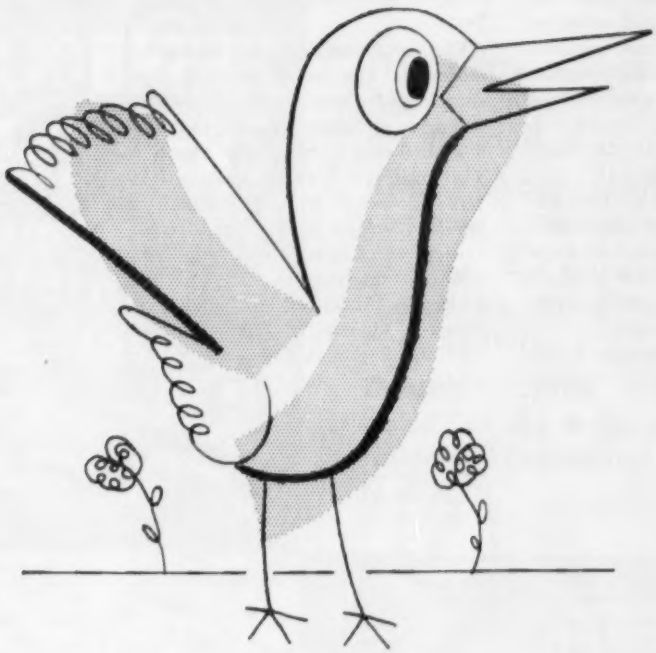
Robert Lyons, assistant administrator of St. Luke's Hospital, Kansas City, Mo., is the new administrator of Atchison Hospital, Atchison, Kan. Mr. Lyons is a graduate in hospital administration from Northwestern University.

Jewell Drake, R.N., has resigned as administrator of Madison Street Hospital, Seattle.

Department Heads

Alvin Miller, former assistant personnel director of Mount Sinai Hospital, New York, has become director of personnel of Beth Israel Hospital, New York. Mr. Miller holds a master's degree in personnel administration from New York University.

William W. Peters, administrative assistant of Westmoreland Hospital, Greensburg, Pa., has been appointed chief admitting officer of Methodist Hospital of Brooklyn, Brooklyn, N.Y. Mr. Peters received his master's degree



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And that's where Elgin-Refinite comes in. Water softening and conditioning is our business. We have been at it for nearly a half century during which we have come up with some of the most important developments in the field.

For example, our water softener of "Double-Check" design makes possible a deeper zeolite bed which increases soft water output as much as 44% —yet it costs so little more. The ingenious "double-check" arrangement also prevents costly loss of zeolite (this arrangement can be easily installed in your present water softener).

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Yes, if you require soft water in large or small quantities, call on Elgin-Refinite for the most advanced, dollar saving equipment your money can buy.

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in hospital administration from the University of Minnesota and served as administrative resident and administrative assistant at Highland Hospital, Rochester, N.Y. He is a nominee of the American College of Hospital Administrators and a member of the American Hospital Association.

George Ollendorf, who has been employed in the accounting department of Wesley Memorial Hospital, Chicago, for the last three years, has been appointed credit manager at Passavant Memorial Hospital, Chicago.

Lucille Hall is now executive housekeeper of Methodist Hospital, Houston, Tex.

Eleanor Dowd, former director of nurses at Children's Hospital, Los Angeles, has been appointed director of nurses at Babies' Hospital-Coit Memorial, Newark, N.J. Miss Dowd is a graduate of Western Reserve University School of Nursing and received her M.A. degree from Columbia University. She has served in administrative and teaching positions at Yale University School of Nursing, Blessing Hospital, Quincy, Ill., and Children's Memorial Hospital, Chicago.

Miscellaneous

V./Adm. Joel T. Boone (M.C., U.S. Navy Rtd.) has retired as chief medical director of the Veterans Administration. **Dr. William S. Middleton,** dean of the medical school of the University of Wisconsin, has been named as the new medical director. Admiral Boone, who has spent nearly 41 years in public service, began his career in 1914 when he was appointed lieutenant, j.g., in the medical corps of the U.S. Naval Reserve; the following year he was transferred to the regular navy. During World War II he was fleet medical officer of the third fleet and served as naval medical corps representative at the Japanese surrender ceremonies on the battleship Missouri. Dr. Middleton received his medical degree from the University of Pennsylvania and joined the staff of the University of Wisconsin Medical School in 1912 as instructor in clinical medicine. He became assistant professor in 1915, associate professor in 1925, and dean of the medical school in 1935. During World War II he served with the army medical corps and was chief consultant for medicine in the European theater. Most recently he has been a member of the advisory council to the assistant secretary of defense for health and medical affairs.

Dr. John M. Whitney, who has served as director of the casualty care division of the health office, Federal Civil Defense Administration, for the last year, has been appointed director of the F.C.D.A. health service. He succeeds **Dr. Robert H. Flinn,** who has been assigned to the office of the chief, Bureau of State Services, U.S. Public Health Service, Washington.

Louise Esch

Louise Esch, assistant superintendent of Stanford University Hospitals, San Francisco, has joined the staff of **Dr. Anthony J. J. Rourke,** hospital consultant, New Rochelle, N.Y. A graduate of the University of Oklahoma, Miss Esch served her dietetic internship at the University of Michigan Hospital and was a member of the dietetic staff of St. Mary's Hospital, Rochester, Minn. She is a member of the American Hospital Association, the American Dietetic Association, and a nominee of the American College of Hospital Administrators.

(*Continued on Page* 212)

Hubert J. Mayrand has retired from his position as assistant to **G. F. Liechty,** assistant director in charge of enrollment, Blue Cross-Blue Shield, Chicago. Mr. Mayrand has been associated with the Chicago plan for 10 years. He previously had been advertising manager of *Hospitals* magazine from 1935 to 1944. At one time Mr. Mayrand was advertising manager of the *Nation's Schools,* which is published by the Modern Hospital Publishing Co.

Trustees

Walter F. Perkins, Baltimore industrialist and chairman of the city airport board, has been elected president of the board of trustees of the Johns Hopkins Hospital following the resignation of **W. Frank Roberts,** who has served in the post since 1948. Mr. Roberts will continue on the board as chairman of the executive committee. Mr. Perkins was elected to the board in 1942 and was named vice president in 1949. **J. Crossan Cooper,** who became a member of the board in 1942, was elected vice president to succeed Mr. Perkins.

Deaths

Dr. E. R. Crew, former superintendent of Miami Valley Hospital, Dayton, Ohio, died recently at the age of 79. A graduate of the University of Illinois, Dr. Crew held the superintendent's post at Miami Valley Hospital from 1912 to 1940, when he retired because of ill health. He was a member of the American Hospital Association, the American Medical Association, and a past president of the Ohio Hospital Association.

Dr. Rudolph Rapp, former superintendent of Grafton State School for Epileptics, Grafton, N.D., died recently at the age of 69. He received his medical degree from Long Island Hospital and for a time was a physician at the Craig Colony, Sonyea, N.Y. From 1917 to 1923, Dr. Rapp served as city health inspector in New York, and until 1945 he was medical superintendent successively of Harlem, Lincoln and Greenport hospitals in New York.

Mrs. N. F. Sundstrom, administrator of Bethel Methodist Home for the Aged, Ossining, N.Y., died recently.

Edward Bennett Close, former managing governor of the American Hospital in Paris, from 1928 to 1941, died recently at the age of 73. After his return to the United States in 1941, he served as an executive in the insurance department of the National Red Cross.

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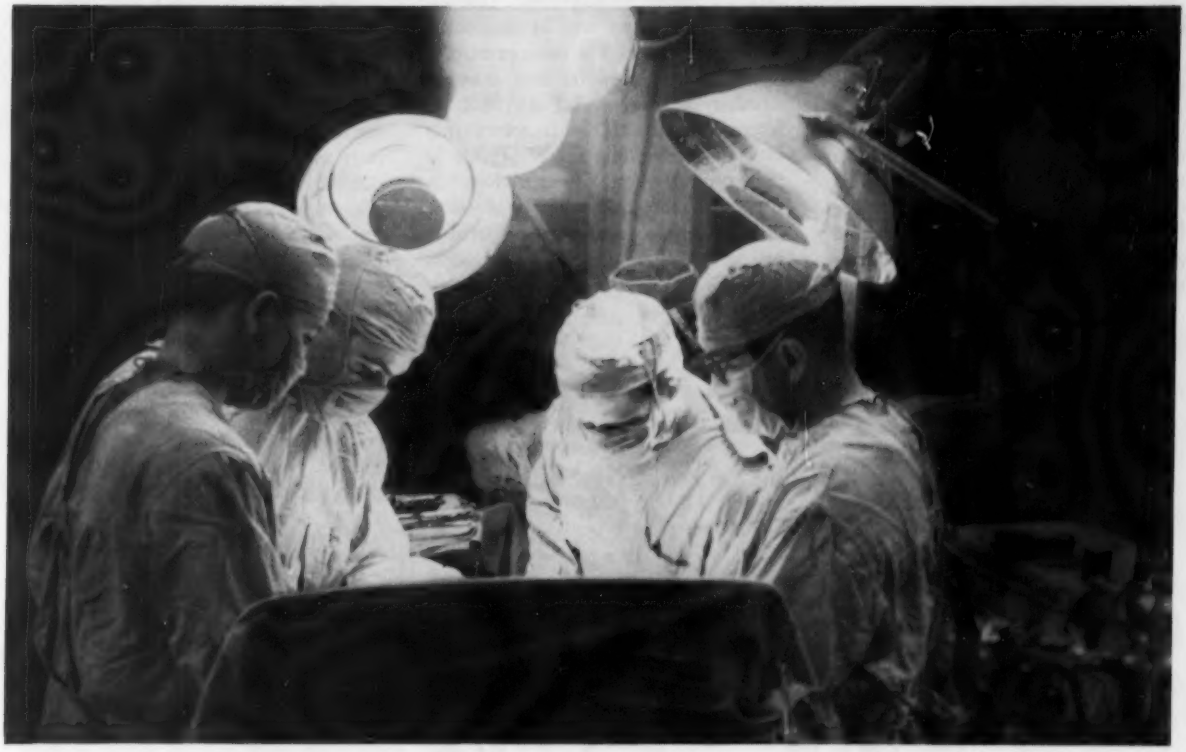

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Let us know what equipment you would like to include in a complete emergency power system and we will recommend the proper equipment and estimate the cost. If you are building a new hospital or remodeling extensively, we suggest that you consult your architect or engineer.

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THE BOOK SHELF

RESTAURANT MENU PLANNING. *By Ann Hoke. Evanston, Ill.: Hotel Monthly Press,* 1955. *Cloth. Pp.* 339. *Price* $5.

A word or two is in order about the author, one of the many women who over the past two or three decades have made interesting and delectable food, of uniformly high standard, available to the public throughout this country. As head of the menu department of a famous chain of restaurants, food stylist for a great hotel, consultant and lecturer at Cornell University's hotel management courses, Mrs. Hoke's views will be welcomed by every dietitian. The basic principles of menu planning differ little if at all, whether in the hospital, the hotel or restaurant, but to me it seems that the job is infinitely more difficult in the hospital where the capricious appetites of the sick must be enticed, not for an occasional luncheon or dinner, but for three meals a day, day after day.

Mrs. Hoke's "chart method" of menu planning (a system not unfamiliar to most dietitians) obviates monotony and Monday's annoying repetition of the preceding Monday's menu. Her suggestions for attractive menu wording, so usable on the selective menu, for eye appeal and color, for a well balanced menu (esthetic fully as much as dietetic) will, I am confident, be well received. Be free with the adjectives, she suggests, when they suitably convey quality, temperature, preparation or color, but be honest about it. Instead of plain "omelette" or "spinach" how much more enticing if it appears as *puffy* or *golden,* as *leaf* or *garden* spinach, as *parsley* potatoes instead of "boiled," as *poached* or *steamed* cod or salmon instead of "boiled." As for hash or hashed, shun these terms like the plague except possibly for "hashed in cream" or "hashed brown" potatoes, Mrs. Hoke urges her readers.

The dietitian in the hospital catering to the carriage trade will be especially interested in the chapter on appetizers or hors d'oeuvres—a bountiful array of nicely worded items like "iced golden apricot nectar" and "minted fresh pineapple cup." Only the marinated herring seems to need no further verbal prop.

Soup, still rather sadly neglected in this country, receives the full V.I.P. treatment from Mrs. Hoke. In 15 pages she offers a liberal education in the garnishes, the types and variations of soups. The chapter on sea food opens new vistas. And when you come to beef, it's not the same old hamburger but "hamburger off the grill with pineapple, broiled bacon, and fresh mushrooms" or "chopped beefsteak Stanley with sautéed banana and horseradish sauce." Faced with such titles for his dishes the most disenchanted chef might be spurred to renewed efforts. Lamb, veal (with considerable space to sweetbreads), pork and ham, poultry (and the cream sauces with which it is pleasantly associated) follow. Then in full array come vegetables "with," and the increasingly popular vegetable plates with helpful sketches of plate arrangements. The same applies to salads.

Perhaps most welcome of all to the dietitian, faced with summer and its labor shifts, is the nearly 40 page section on cold plates which lists 109 selections. Eggs and desserts close the food chapters, the latter divided into seasons.—MARY P. HUDDLESON.

...More and More Hospitals
Adopt
Aloe Contour Breast Pads

Late last fall, the Aloe Company introduced an entirely new shaped, absorbent breast pad. Now hundreds of hospitals in all parts of the country have adopted as routine this better way of handling the problem of excess lactation.

The experience of Creighton Memorial St. Joseph's Hospital, Omaha, Nebraska, is an example of the acceptance of this remarkably successful product. Mr. Francis Bath, Business Manager, writes:

"... We believe that St. Joseph's was one of the earliest of the hospitals to use this breast pad in the maternity department, where it has won favor not only with the personnel, but even more among the patients. We have had several mothers who have taken home as many as six boxes . . 4!

"Sister Mary Corneliana, O.S.F., O.B. Supervisor, is enthusiastic about the pad, as she finds it much more satisfactory than the sponges which were used formerly."

This shaped pad was one of those ideas the need for which had been felt for a hundred years or more, but about which little was done. Nurses and supervisors have always known that there must be a better way of stemming the flow of excess lactation in new mothers than that of using irritating gauze sponges, make-shift cut pads or lumps of cotton under the bra.

It takes hours of hospital personnel time to "manufacture" such improvised pads, and additional labor time to apply, with the results seldom satisfactory. Hospitals speedily recognized the obvious advantages of a prepared, scientifically designed pad, when we introduced it.

Aloe Takes No Credit for suggesting the shaped Breast Pad. Actually a physician friend of the Company decided that the time for such a pad was long overdue. Nature and common sense dictated the design. We merely placed the problem of production before an experienced manufacturer, with the stipulation that materials must be of the finest and that control of quality must be rigid.

The Natural Contour Shape and perfect absorbency of Aloe Contour Breast Pads are responsible for their instant acceptance. Anatomically formed to fit the breast with full coverage of nipple, areola and a generous adjacent area (3¾ inches in diameter), they are unobtrusive in appearance and afford complete protection to the patients' clothing. Patients, of course, overwhelmingly endorse them.

The Pads are made of cotton, filled with soft, highly absorbent cellulose —non-allergenic, non-irritating, helpful in preventing retracted and cracked nipples; a great aid in applying medication. They are packaged one dozen (average daily supply per mother) in an attractive carton; easy to dispense; labor saving; generally applied by the mother herself. Easy to store. They are disposable and therefore eliminate repeat sterilization. Patients usually want to purchase an extra supply from the hospital dispensary for continued use at home.

Among Aloe Contour Breast Pad users are:

Ball Memorial Hospital
Muncie, Indiana

Centro Asturiano Hospital
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Creighton Memorial St. Joseph's Hospital
Omaha, Nebraska

Good Samaritan Hospital
Sandusky, Ohio

Hutchins Memorial Hospital
Buford, Georgia

Lee Memorial Hospital
Fort Myers, Florida

Marymount Hospital, Garfield Heights, Ohio

McLaren General Hospital
Flint, Michigan

Mease Hospital, Dunedin, Florida

Mercy Hospital, Toledo, Ohio

Misericordia Hospital
Milwaukee, Wisconsin

Munroe Memorial Hospital
Ocala, Florida

Ohio Valley General Hospital
Wheeling, West Virginia

Passavant Memorial Hospital
Jacksonville, Illinois

Roper Hospital
Charleston, South Carolina

Self Memorial Hospital
Greenwood, South Carolina

South Carolina Baptist Hospital
Columbia, South Carolina

St. Anthony's Hospital
St. Louis, Missouri

St. Joseph's Hospital, Milwaukee, Wisconsin

St. Joseph's Mercy Hospital
Pontiac, Michigan

St. Luke's Hospital
Kansas City, Missouri

St. Mary's Hospital, Athens, Georgia

St. Mary's Hospital
Kansas City, Missouri

Tallahassee Memorial Hospital
Tallahassee, Florida

Tampa Municipal Hospital
Tampa, Florida

The Valley Hospital, West Point, Georgia

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Kansas City, Kansas

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Winter Haven, Florida

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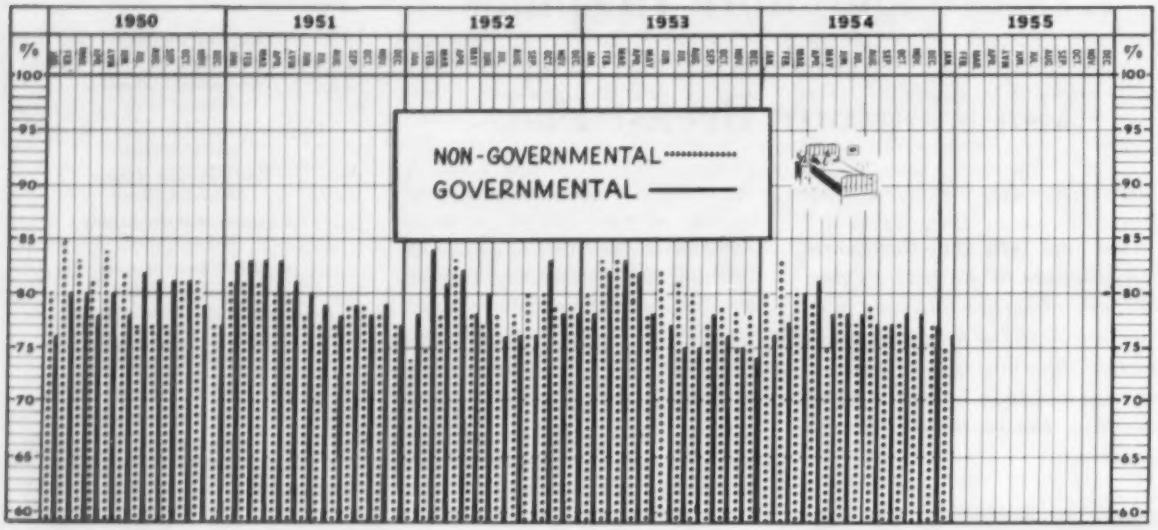
Voluntary Hospital Occupancy Rises in January



Occupancy of voluntary hospitals reporting to the Occupancy Chart for January 1955 was 74.6 per cent of capacity, slightly higher than the occupancy for the previous month. Occupancy of government hospitals for January 1955 was 76.3 per cent, compared to 73.6 per cent a year ago.

New hospital construction reported for the second period in 1955 totaled $58,103,050; total for the year to date was $98,830,000, compared to $106,966,000 for the same period last year. Among the 56 current projects, 20 were new hospitals, 32 were additions to existing hospitals, two were modernization projects, and two were nurses' residences.

Proven in use all across the country . . .

a low-cost room thermostat system for existing hospitals!

Individual Room Temperature Control
now possible . . . room by room . . . to fit your budget

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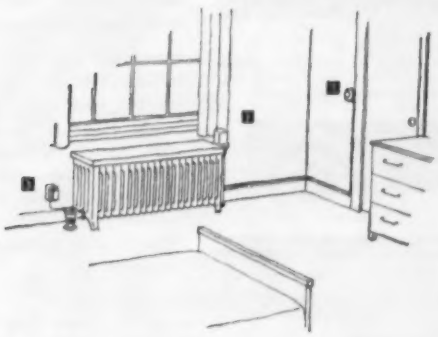

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Despite constant exposure to heavy traffic, spilled food, grease, and liquids, the Terraflex floor in the cafeteria of the Sperry Gyroscope Company at Lake Success, L. I. shows no sign of wear—looks as fresh and colorful as the day it was installed.

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Vinyl-Asbestos Tile Floor

provides beauty, color and wear with minimum care.

IN ADDITION to their inviting appearance, the floors in the busy cafeteria, the railroad car and the major air-passenger terminal, shown here, have one other important common characteristic. Each is a Johns-Manville Terraflex Tile floor . . . selected to meet stringent requirements for heavy-traffic floor service with the lowest possible maintenance cost.

Made of vinyl and asbestos J-M Terraflex is exceptionally tough and resistant to wear . . . defies grease, oil, strong soaps and mild acids.

Terraflex can reduce maintenance costs one half. In actual use, tests showed Terraflex maintenance expense to be approximately 50% less than the next most economically maintained resilient flooring. Its nonporous surface requires no hard scrubbing, damp mopping usually keeps it clean and bright . . . frequent waxing is eliminated. Through years of economical service Terraflex pays for itself.

Available in a range of 15 marbleized colors, J-M Terraflex vinyl-asbestos tile is ideal for restaurants, public areas, schools, hospitals—wherever reliable floor service, long-wearing beauty and long-time economy must be combined.

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ANESTHETIST—M.D., female; 30, trained at outstanding center; 5 years experience; available soon. Apply MW 77, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

BUSINESS MANAGER—4 years experience, purchasing agent and credit manager, 100-bed hospital; also 10 years experience, operating small business. Apply MW 75, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR—Public relations; B.S. degree in journalism June 1, 1955; background in hospital work as medical record library director; available June 15, 1955. Apply MW 74, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ENGINEER—Chief; graduate mechanical; 600-beds and over; qualified to supervise technical engineering staff and mechanics of all crafts; to assume responsibility for planning new construction, major internal relocations and repair projects; twenty years experience in all phases of maintenance of power and heating plants, air conditioning, refrigerating systems and building appurtenances; possess special talents in the successful handling of men and planning work with minimum of interference with normal function of activities. Apply MW 72, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LIBRARIAN—Medical record; B.S. degree; 15 years experience in organizing and managing departments; minimum salary $5500; available June 15, 1955. Apply MW 73, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PATHOLOGIST—Certified clinical and anatomic pathology; age 38; category IV; associate professor; extensive surgical pathology, teaching, research, publications; desire hospital appointment; prefer academic and research possibilities. Apply MW 63, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

RADIOLOGIST—32; category IV, certified, diagnosis and therapy; 2 years assistant professor radiology associated with large teaching hospital, desires hospital department directorship. Reply MW 70, The Modern Hospital, 919 N. Michigan Avenue, Chicago, 11.

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PATHOLOGIST—Diplomate, (Pathologic Antomy; Clinical Pathology); three years' full time teaching; six years, director of pathology, 300-bed general hospital.

RADIOLOGIST — M.D., Jefferson; three-year residency, university hospital; three years, associate radiologist, large teaching hospital, instructor in radiology, medical school; Diplomate.

ANESTHESIOLOGIST — Trained university hospitals; past 6 years successful private practice, anesthesiologist and director department 100-bed general hospital (fee basis); primarily interested cities offering primary and secondary private school educational facilities for his children; seeks director larger hospital; Diplomate, FACA; early 40's; Category IV.

ADMINISTRATOR—33; B.S., Business Administration; 5 years business manager, 125-bed hospital; 4 years assistant administrator, general hospital 200-beds; 1 year assistant administrator, 350-bed hospital; well-prepared to administer hospital 100 to 250-beds; member ACHA.

ADMINISTRATOR — Medical; M.S., Hospital Administration; 5 years Lt. Col. USAMC; 5 years administrator university hospital 400-beds; Member ACHA.

(Continued on page 222)

WOODWARD—*Continued*

ADMINISTRATOR—B.A.; M.S., Hospital Administration; 2 years administrative residency university hospital; 5 years administrator 120-bed general hospital; member ACHA.

ADMINISTRATOR — Clinic Manager; B.A., M.A,. PhD, (languages), M.S. Hospital Administration; 4 years army adjutant's office; 5 years, clinic manager hospital administrator, hospital group 50-beds; 2 years, clinic manager important 11 man group; recommended as above-average in devotion to duties, personable, co-operative, with ability to meet public; member NACM; late 30's; any locality.

ADMINISTRATOR — Male; B.S., (Psychiatric Nursing Education); MPH (Hospital Administration), University of Pittsburgh; administrative residency, large Southern hospital; 6 years experience, staff and supervisory nurse before specializing; prefer south.

ADMINISTRATIVE ASSISTANT — 29; B.A.; M.S. Hospital Administration; completed 1 year administrative residency; 700-bed general voluntary hospital; seeks administrative assistantship hospital 200-beds up or administrator hospital 50 to 100-beds.

DIRECTOR OF NURSES—Male, M.S. (Nursing Service Administration) Boston University; 9 years staff and supervisory experience, mainly psychiatric; prefer appointment in psychintric hospital, any location.

INTERNIST—With special interest allergy and chest diseases; M.D., Virginia; residency 1 year each medicine, allergy, chest; univerasity hospital; board eligibility, 3 years, WWII; early 30's, recommended as being superior in every category of post-graduate training, having originality, excellent clinical judgment; with some academic background, handsome, delightful, tall young man.

PATHOLOGIST—Trained university hospital; 2 years assistant pathologist 350-bed teaching hospital; 1 year chief pathologist 500-bed hospital and assistant professor, pathology important university medical school; Diplomate, anatomy, eligible clinical; middle 30's.

PATHOLOGIST — Long tenure as assistant pathologist 3000-bed teaching hospital; 6 years director department pathology general hospital, 250-beds; prefers east, northeast; Diplomate, pathologist anatomy; draft exempt.

PURCHASING DIRECTOR — Woman; 29; single; 10 years assistant purchasing agent, university hospital 500-beds; seeks position as purchasing director smaller hospital or assistant larger hospital; prefers midwest.

PURCHASING DIRECTOR — B.A., past 6 years purchasing director, inventory control, 200-bed hospital; fine man in late 20's; widower; seeks hospital 250-400 beds.

RADIOLOGIST—M.D., Harvard; trained teaching hospitals, 1 year, assistant radiologist 500-bed teaching hospitals; 3 years assistant radiologist important diagnostic clinic-hospital and instructor radiology, university medical school; seeks chief or associate, department radiology, general hospital; Diplomate, diagnostic and therapeutic; including radium; early 30's.

classified advertising

POSITIONS WANTED

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

EXECUTIVE HOUSEKEEPER—2 years college; 10 years assistant to outstanding executive housekeeper; past 4 years supervisor of maintenance 400-bed eastern hospital; highly recommended.

ASSISTANT ADMINISTRATOR — Graduate University of Pittsburgh; M.H.A. Degree, 1954; served residency and one year's assistantship, 200-bed eastern hospital; available May.

BUSINESS MANAGER—B.S. Degree, Business Management; 5 years public accountant; past 3 years assistant comptroller, 300-bed western hospital.

BUSINESS MANAGER—CPA: 10 years comptroller, 200-500 bed hospitals, east; available.

ADMINISTRATOR — M.S. Degree, Hospital Administration. Age: 33 years; 3 years assistant administrator, 400-bed Ohio hospital; 2 years administrator, 80-bed Michigan hospital.

NURSE SUPERINTENDENT — Registered, New York, Michigan, Ohio. 6 years surgery supervisor; 10 years, administrator, 40-85 bed hospitals; excellent in public relations.

POSITIONS OPEN

ADMINISTRATOR—For 26-bed county hospital; construction starting, with planned future expansion, on site overlooking Lake Freeman, Indiana's finest resort area; applicant must prove successful previous operations. Apply White County Memorial Hospital Board, Monticello, Indiana.

ANESTHETIST—Resident; salary open; California hospital; excellent opportunity; permanent; Apply, Dr. J. H. Thayer, 2001 Hoover Street, Los Angeles 7, California.

ANESTHETISTS—Nurse; for 150-bed general hospital; four nurses, full-time M.D., all agents and techniques; one month's vacation; two and one-half hours from Boston and New York. Write, G. J. Carroll, M.D., Chief of Anesthesia Department, William W. Backus Hospital, Norwich, Connecticut.

ANESTHETIST — Nurse; 300-bed approved hospital in Detroit area; salary $400 per month, time and a half for overtime, double time for Sundays and holidays; 18 sick days yearly. Apply I. D. Nickerson, M.D., Anesthesia Department, Highland Park General Hospital, Highland Park 3, Michigan.

ANESTHETIST—Ideal opening on staff of three; 153-bed voluntary hospital associated with private clinic in summer-winter resort area; wide experience, salary open. Apply Little Traverse Hospital, Petoskey, Michigan.

ANESTHETIST—Nurse; for an old established group; good starting salary and permanent position. Apply The Sugg Clinic, Ada, Oklahoma.

ANESTHETIST—Registered nurse; New 250-bed, well equipped general hospital; department directed by medical anesthesiologist, cooperative medical staff and personnel; good personnel policies; salary depends on experience, minimum $414.00 with periodic merit raises. Apply, Director, McLaren General Hospital, 401 Ballenger Highway, Flint 2, Michigan.

ANESTHETIST—Nurse; male or female; 75-bed hospital associated with group; modern equipment; salary $500.00 per month, paid vacation, holidays, sick leave policy; college town of 8000. Apply, Bashline Hospital, Grove City, Pennsylvania.

ANESTHETISTS—3 nurse anesthetists to increase staff; approved A.A.N.A. training school; good working conditions; medical anesthesiologist in charge of department. Apply Director, Department of Anesthesiology, Lancaster General Hospital, Lancaster, Pennsylvania.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

(Continued on page 224)

Remington Rand

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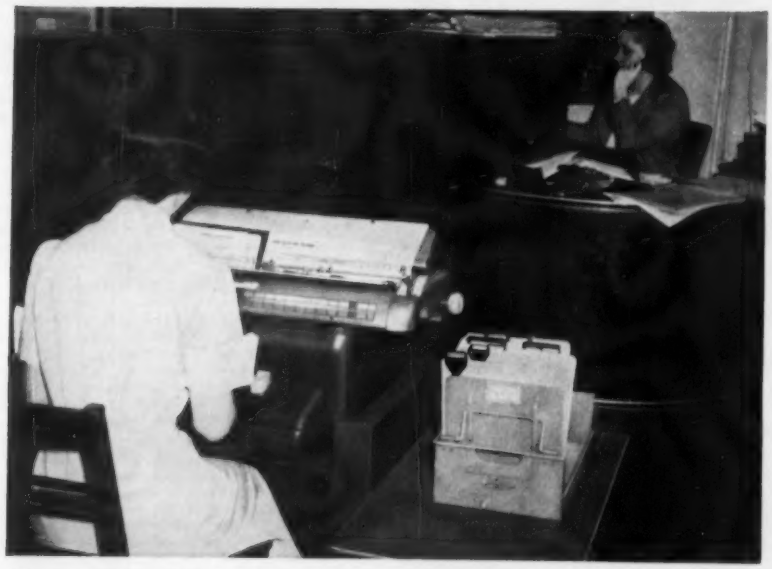
For Greater Profits Through Lower Costs



New Machine Accounting Method Eliminates Separate Writing of Blue Cross Reports

Hospitals can save valuable clerical time by adopting the Remington Rand Combined Patient Statement and Blue Cross Report accounting method. The statement is designed so that a carbon copy provides Blue Cross and other Insurance Companies with required information and serves as your report. One writing posts all records simultaneously—with touch-method speed, typewriter simplicity.

And because machine methods keep records up-to-date, your statements are always ready for the patient—whenever he may be discharged. They're complete with full description of entries to prevent misunderstandings, simplify reference and speed auditing. And the neat, machine-accurate appearance reassures the patient and insurance people that all charges are correct.

Many hospitals now use Remington Rand mechanized accounting methods for patient accounting, accounts payable, inventory and payroll—with amazing results. They get a complete picture of receipts and expenditures—*as an automatic by-product of normal posting!*

Send for details. Circle **SPAB 4543** and **SPAB4544** on coupon.

One Minute to Locate a Case History Number in Huge File

The Los Angeles County General Hospital has to maintain records for approximately 1,400,000 individual case histories. Yet they locate the Case History Number from a cross index file in an average time of less than *one minute!*

This efficiency has been made possible largely because of Soundex – the indexing system that groups similar names according to a simple code, rather than by their exact spelling. It's a tried, efficient solution to the endless possibilities for error found in a large "indexed-by-spelling" file.

To get all the details on how it works for the Los Angeles General, circle **SPLV4192** and **LBV 528** on the coupon.

One-Third More Records in the Same Filing Area

Now you can have *four-drawer* counter-height files for your medical record library instead of the standard three-drawer units—an increase of ONE-THIRD in filing capacity. And for your active records, a *practical* six-drawer letter or legal size file is now available.

KOMPAKT, the "file with the extra drawer," gives you exactly that. Every bit of space wasted

in ordinary file cabinets has been carefully utilized, picking up an inch here, an inch there to give you *maximum* filing capacity.

Get all the details on these space-making new file cabinets. See how KOMPAKT can save you valuable office space. Circle **LBV692** on the coupon below.

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SPAB4544 **LBV528**

Name_____

Title_____

Hospital_____

Address_____

City_____ Zone____ State_____

H-10

classified advertising

POSITIONS OPEN

DIETITIAN—Full charge ADA for 135-bed hospital fully approved; in metropolitan area of northeast Ohio. Apply MO 97, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—Assistant to chief; general hospital for men, women and children; duties involve therapeutic diet planning, patient contact, assist in general supervising and some tray checking. Apply The Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—Chief; ADA member, 306-bed hospital with large clinic and full-time medical staff of 32; good salary and good personnel policies. Apply Administrator, Geisinger Memorial Hospital, Danville, Pennsylvania.

DIETITIAN—110-bed hospital, salary depends on experience and qualifications; 60 miles east of Pittsburgh on Pennsylvania Turnpike. Apply Administrator, Somerset Community Hospital, Somerset, Pennsylvania.

DIETITIAN—Chief therapeutic; duties for 650-bed hospital in Texas Medical Center; salary open. Apply, Director of Dietitics, Hermann Hospital, Houston 25, Texas.

DIRECTOR OF NURSING SERVICES—Immediate permanent Civil Service position in a 500-bed County home for aged; must have had two years of study in an approved college and two years in high level supervision; California registration required before appointment; salary $378-$460 monthly for 40-hour work week. Apply County Civil Service, 402 Civic Center, San Diego, California.

DIRECTOR OF NURSING SERVICE—280-bed fully approved general hospital; must be qualified by preparation and experience; Degree required; full maintenance in comfortable living quarters; 40 hour week; salary open pending type of professional background; position available immediately. Apply Administrator, Chester Hospital, Chester, Pennsylvania.

HOUSEKEEPER — Executive; 275-bed voluntary, non-profit hospital, with new and old section; renovation program; must have administrative and teaching ability. Apply Administrator, Woman's Hospital, Detroit 1, Michigan.

INSTRUCTOR—Clinical for surgical nursing in 200-student school, affiliated with Drake University; 400-bed, fully approved, non-profit hospital; desire person with B.S. degree plus qualifying experience; will consider nurse without degree who can show outstanding experience and ability; work with select, enthusiastic, stable student body; salary open; 40-hour work week; 22 working days vacation; sick benefits; position open immediately. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa

INSTRUCTOR—Clinical; for medical and surgical nursing; advanced preparation and experience or degree in nursing education required; salary open. Apply Flower Hospital School of Nursing, Toledo, Ohio.

INSTRUCTORS—Clinical; 1 medical and 1 obstetrical, for 502-bed hospital in Philadelphia area; salary based on qualifications of applicant; automatic salary increases; 40-hour week, 28 days vacation, 14 days sick leave; Blue Cross plan available; teaching duties only; opportunity to pursue additional university courses. Apply Director, School of Nursing, Cooper Hospital, Camden, New Jersey.

INSTRUCTOR—Clinical; for obstetric department of 65-beds in 225-bed hospital; 130 students in school of nursing; assume full responsibility for classroom and ward teaching in obstetrics; salary open; Apply Tacoma General Hospital, School of Nursing, 314 South K Street, Tacoma, Washington.

LIBRARIAN — Registered medical record; to head department of 275-bed, voluntary, non-profit J.C.A.H. approved hospital; department requires organizational and administrative ability; active medical record, medical audit and tissue audit committees. Apply Administrator, Woman's Hospital, Detroit 1, Michigan.

LIBRARIAN—Registered medical record; to head well organized department in 325-bed, non-sectarian, approved general hospital; university affiliated; successor to oldest hospital in Michigan; located in downtown Detroit; liberal personnel policies; good working conditions good salary; prefer person interested in punch card statistics and microfilmed records. Apply Administrator, Detroit Memorial Hospital, 1420 St. Antoine Street, Detroit 26, Michigan.

(Continued on page 226)

Nurses' station, St. Joseph's Hospital, Phoenix, Arizona. Note attractive ceiling of incombustible Celotone® mineral fiber tile.
Acousti-Celotex Contractor: Laing-Garrett Construction Specialties, Inc.

Rx: QUIET...

Taken 24 hours daily for quicker convalescence

A vastly important adjunct to medical and surgical treatment . . . is a favorable atmosphere for patient recuperation. It is indeed ironic that one of a hospital's most insidious enemies is the disturbing din that comes from normal daily routine within its rooms and corridors. Far-sighted, though, is the hospital that looks to Acousti-Celotex Sound Conditioning to combat elements that retard the process of getting well.

Double-Duty Solution—Countless of the nation's hospitals have found the perfect two-way answer in a sound-absorbing ceiling of Acousti-Celotex Tile. First, a new attractive look is brought to room appearance. And second, and most important, irritating noises rising from corridors, lobbies, kitchens, utility rooms are checked . . . prevented from filtering into wards, nurseries, operating and delivery rooms. The *quiet comfort* that results not only helps speed patients' recovery, but also improves working efficiency of hospital personnel.

Maintained with Ease—This functional as well as beautiful contribution is standard with Acousti-Celotex Tile. Its high sound-absorption value is as remarkable as the eye-appeal of its variety of handsome surfaces. Quickly installed, it needs no special maintenance. And the unusual tile can be washed repeatedly and painted without loss of sound-absorbing properties.

Mail the Coupon for a Sound Conditioning Survey Chart that will bring you a *free analysis* of the noise problem in your hospital, plus a free factual booklet, "The Quiet Hospital." No obligation, of course.

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Sound Conditioning
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Products for Every Sound Conditioning Problem—The Celotex Corporation, 120 S. LaSalle St., Chicago 3, Illinois • In Canada: Dominion Sound Equipments, Ltd., Montreal, Quebec.

Mail Coupon Now!

The Celotex Corporation, Dept. G-35
120 S. LaSalle St., Chicago 3, Illinois

Without cost or obligation, please send me the Acousti-Celotex Sound Conditioning Survey Chart, and your booklet, "The Quiet Hospital."

Name_____ Title_____

Hospital_____

Address_____

City_____ County_____ State_____

classified advertising

POSITIONS OPEN

MEDICAL DIRECTOR—North American graduate; five years tuberculosis experience, relatively new 100-bed tuberculosis hospital, Madisonville, Kentucky, salary $19,000, complete maintenance. Apply State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

NURSES—Staff nurses needed at Veterans Administration Hospital with general medical and surgical services, including tuberculosis, neuropsychiatry, and paraplegia, located in suburban Chicago; 40-hour week, rotating shifts, starting salary $3740.00, junior grade; higher grades and salary depending on qualifications; periodic $100 increase in salary; 8 holidays, 30 days annual leave and 15 days sick leave yearly; a maximum of 120 days annual leave can be accumulated, and the accumulation of sick leave is not limited; current registration in one of the States of the United States or District of Columbia is required; maintenance on the station with three meals available at minimum cost; universities are accessible in the area for nurses interested in furthering their education. Further information and application forms may be obtained by writing:
Chief, Nursing Service, Hines, Illinois.

NURSES—Operating room; 200-bed hospital; new operating room in near future; advanced preparation desired. Apply Flower Hospital, Toledo, Ohio.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Psychiatric; openings in state mental hospital for educational director (psychiatric nurse II) and psychiatric nurses for staff and supervisory positions; good personnel policies, salary commensurate with experience and qualifications; chance for educational advancement through Kansas University and Hays State College, extension courses given at the hospital. Apply to Personnel Officer, Larned State Hospital, Larned, Kansas.

NURSES—Operating room; at Medical Center; start $270; increases at 6 months, 1 year and 2 years; overtime premium pay; paid vacation; 6 paid holidays; sick leave; social security; we pay hospitalization insurance, life insurance, retirement annuity. Apply Personnel Director, Rochester Methodist Hospital, Rochester Minnesota.

NURSES—Registered; for operating room and general floor duty. Apply, Wooster Community Hospital, Wooster, Ohio.

NURSE—Supervisor; for a 38-bed psychiatric hospital; $350 to $400 per month; experience in psychiatric and administrative nursing preferred; position available in March or sooner. Write giving qualifications or apply in person to Crestview Hospital, 145 West College Avenue, St. Paul, Minnesota.

NURSES—Registered; all shifts; liberal benefits; new hospital located in beautiful Ohio Valley; at present 26-beds and being enlarged to 56-beds; openings immediately. Apply, Rozella Wilson, R.N., Director of Nurses, Adams County Hospital, West Union, Ohio.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered; for operating room and general floor duty. Two general floor supervisors—one for 3-11 and one for 11-7. Apply, Martinsville General Hospital, Martinsville, Virginia.

NURSES—Registered; salary $160.00 per month with full maintenance; eight hour rotating shifts with one day off each week and one extra day every second week; eight legal holidays, vacation and sick allowance each one and one-half days monthly; complete new unit under construction. Apply Superintendent, Lady Minto Hospital, Cochrane, Ontario, Canada.

(Continued on page 228)

New study confirms
T. E. D. Elastic Stocking Routine SAVES LIVES

In a study of 9,917 hospital patients, the expected incidence of fatal pulmonary embolism was reduced 65% at a cost of about 2½¢ per bed per day.

Conclusions reached earlier—that routine use of T.E.D. Elastic Stockings significantly reduces incidence of fatal pulmonary embolism among hospital patients—have been amplified.

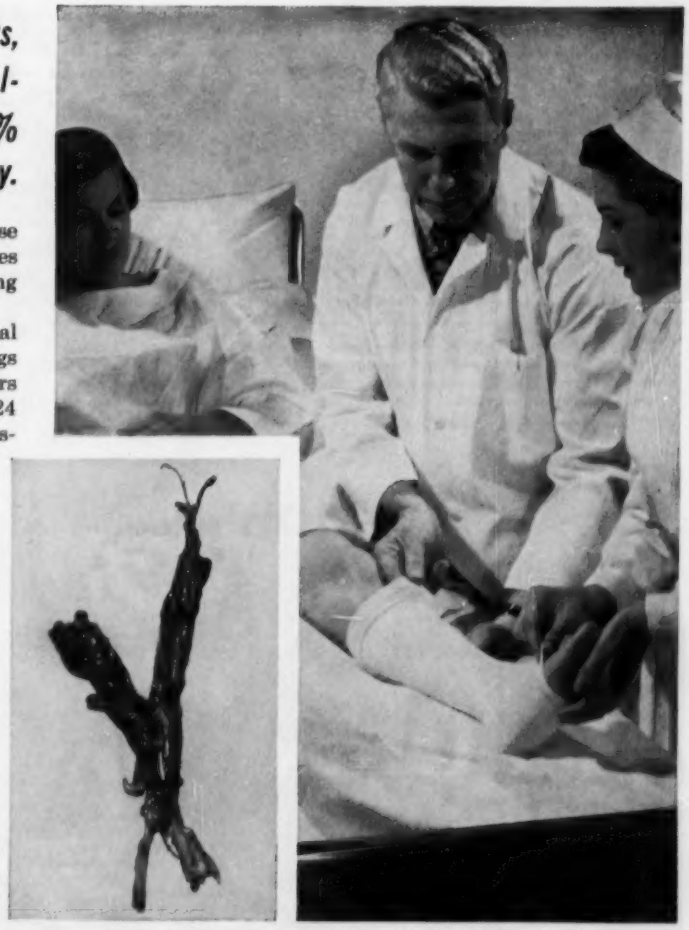
In new studies at Massachusetts Memorial Hospitals in Boston, T. E. D. Elastic Stockings were applied routinely to *all* patients over 21 years of age admitted to the hospital for more than 24 hours (except in cases of ischemic vascular disease of the legs in which use of the stockings is contraindicated). Data on the incidence of pulmonary embolism was carefully compiled and conservatively interpreted.

The Result: Expected incidence of fatal pulmonary embolism was reduced by 65%.

The majority of fatal emboli result from circulatory stasis incident to bed rest. In most cases they originate in the deep calf veins of the leg—an area in which prophylaxis is easily accomplished by simple compression of the leg.

T.E.D. Elastic Stockings, a new type of inexpensive elastic stockings, provide this compression efficiently and at low cost. They exert just enough pressure to speed blood flow through the deep calf veins, thus minimizing clot propagation. T. E. D. Stockings were developed exclusively by Bauer & Black in cooperation with Massachusetts Memorial Hospitals.

A complete report of the above study appeared in the New England Journal of Medicine. You may have a reprint of this article for your files by writing to Bauer & Black Research Laboratories, 309 W. Jackson Blvd., Chicago 6, Ill.



Specimen of deep calf veins opened to show ante mortem clot filling peroneal and posterior tibial veins. From such clots fatal and non-fatal pulmonary emboli result. *(Specimen photograph courtesy of Joseph R. Stanton, M. D., Massachusetts Memorial Hospitals and Boston University School of Medicine.)*

COST OF T. E. D. STOCKINGS AVERAGES LESS THAN 2½¢ PER BED PER DAY

The quantity price of T.E.D. Elastic Stockings is only $2.45 per pair. When you furnish 3 pairs per active bed per year the cost averages only 2⅓ cents per day.

T. E. D.®

ELASTIC STOCKINGS

BAUER & BLACK

Division of The Kendall Company

classified advertising

POSITIONS OPEN

NURSES—General duty; all services, 320-bed hospital; unhappy with the snow? Come to sunny Arizona, home of the Grand Canyon; watch movies being made in Sedona; only 185 miles south is romantic Mexico; minimum starting salaries, $245 evenings, $240 nights or rotation, $230 days; 40-hour, five day week, merit raises every six months for three years, paid vacation, sick leave and holidays, Blue Cross available, social security. Write Director of Nursing, Good Samaritan Hospital, Phoenix, Arizona.

RESIDENT PHYSICIAN—Pathologist, X-ray; one able to obtain California license and who could qualify in co-staff hospital. Contact Dr. J. H. Thayer, Metropolitan Hospital, 2001 South Hoover, Los Angeles 7, California.

SUPERVISOR—Obstetrics; responsible for supervision of small unit and teaching program in obstetrics; California registration, academic degree and successful experience in obstetrics required; salary $365; forty-hour week, paid vacation and sick leave and Blue Cross hospitalization provided. Apply Director of Nursing, French Hosptial, San Francisco, California.

SUPERVISOR and INSTRUCTOR—Obstetric; administrative and teaching responsibilities; salary open, depending upon qualifications. Apply Flower Hospital, Toledo, Ohio.

SUPERVISOR — Obstetric; modern 115-bed hospital; administrative responsibility for 28 beds and 29 bassinets; approximately 1000 deliveries yearly; graduate staff; advance preparation and experience required. Write Director of Nursing, Mount Sinai Hospital, Hartford, Connecticut.

SUPERVISOR—Hospital for convalescent orthopedic and medical children; 40-hour week; one month vacation and two weeks sick leave annually; B.S. preferred; salary dependent on qualifications. Apply Children's Convalescent Home, Cincinnati 19, Ohio.

SUPERVISORS — Operating room supervisor and assistant supervisor; salary open; complete maintenance if desired. Shriners' Hospital for Crippled Children, Philadelphia 15, Pennsylvania. MA 4-0700.

TECHNICIAN—Registered laboratory; for 265-bed teaching hospital, located on Chicago's near-north side; modern laboratory; starting salary $290 month; alternate 5 and 6 day week; merit increases; excellent employee benefits including 4 weeks vacation; 12 days sick leave; laundry furnished and a 50% tuition reduction on courses at Northwestern University. Apply Passavant Memorial Hospital, 303 East Superior Street, Chicago 11, Illinois.

TECHNICIAN—Laboratory; A.S.C.P. registered; very modern hospital in popular resort area to take complete charge in completely equipped laboratory; excellent call arrangement, above average salary; unusual opportunity for alert capable person; send photo and particulars to Schoolcraft Memorial Hospital, Manistique, Michigan.

TECHNOLOGIST—Medical; experienced; capable of taking complete charge of laboratory; 70-bed air conditioned modern hospital; good working conditions, congenial staff, friendly community. Apply Superintendent, Montgomery County Hospital, Conroe, Texas.

The Medical Bureau

M. BURNICE LARSON—DIRECTOR

Telephone DElaware 7-1050

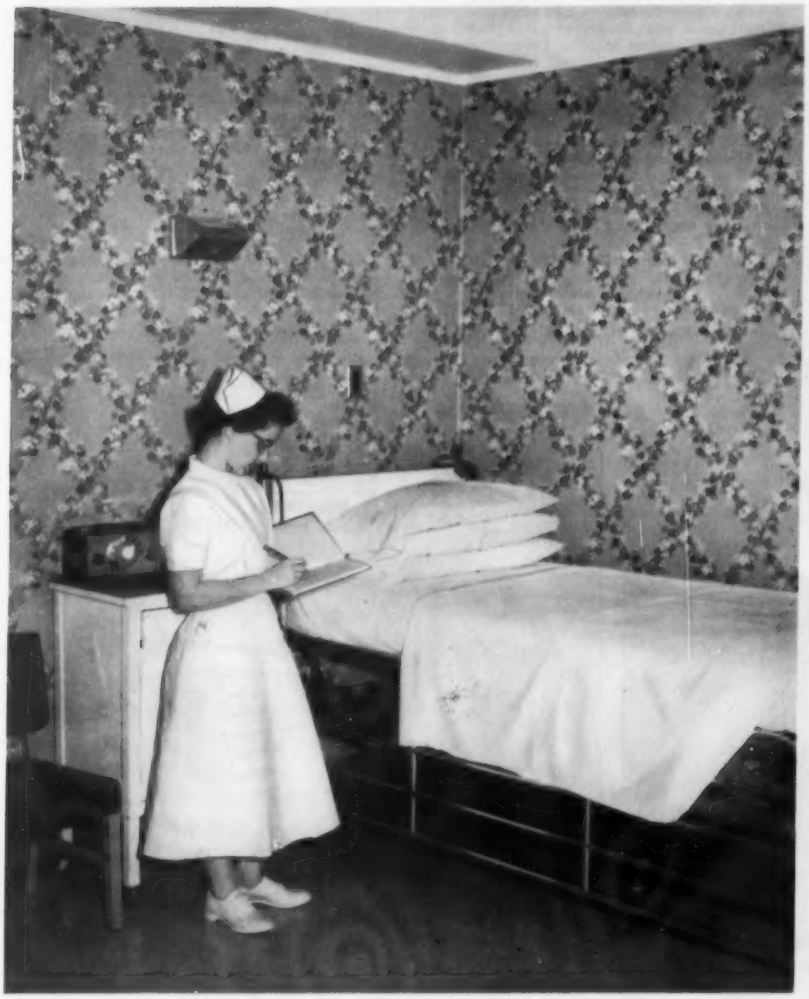
PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) Medical; teaching hospital, 800-beds; extensive building program; leader of experience qualified to direct entire medical center required. (b) Medical; 300-bed general hospital; teaching program; university city, Pacific coast. (c) Voluntary general hospital, 275-beds; expansion program; challenging opportunity; New England. (d) Assistant medical; new 500-bed teaching hosiptal; northwest. (e) Medical or non-medical; 425-bed general hospital; unit, university group; east. (f) Voluntary general hospital, 135-beds; Pa-

(Continued on page 230)

"Wallpaper does double duty"

Says Mr. Wm. G. Vollus, Executive Secretary,
Arabia Temple Crippled Children's Clinic, Houston, Texas.



"WALLPAPER in patients' rooms," says Mr. Vollus, "makes for a very homelike atmosphere that does double duty in economy and ease of maintenance. In addition to its smart decorating effect, we have found that wallpaper has a certain therapeutic value so far as the patients' recuperative powers are concerned."

Hospitals everywhere are turning to wallpaper for durability, economy and for the cheerful well-being of patients and staff. Why not investigate the advantages of wallpaper in your hospital?

In hospitals, too . . . *Wallpaper is Smart!*

WALLPAPER COUNCIL
509 Madison Avenue, New York 22, N. Y.

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

cific northwest. (g) Medical or non-medical to serve as consultant, voluntary organization, 5000 beds; foreign assignment, three years; knowledge of Spanish or French required. (h) General hospital, 125-beds; southwest. (i) Assistant by medical administrator, large teaching hospital; attractive city; young medical or non-medical administrator considered. (j) Assistant; preferably one strong in public relations or personnel administration; 700-bed general hospital; east. (k) Clinic manager; 27-man group. MH3-1

ADMINISTRATORS—Professional Nurses; (a) Assistant administrator in charge of nursing service; voluntary general hospital, 175-beds; building program; residential town, midwest; $6000, apartment. (b) New hospital, 50-beds; resort town, south. MH3-2

ANESTHETISTS—(a) General 175-bed hospital; college town, Pocono Mountain area; short distances, New York City, Philadelphia; $5400. (b) Voluntary general hospital, 400-beds, modern in every way; attractive city, outside United States; mild pleasant climate. (c) Relatively new hospital, 200-beds; suburb, large city, midwest; $6-$7000. (d) New general hospital, 300-beds; department headed by well qualified medical anesthesiologist; university town, Carolinas. MH3-3

MEDICAL BUREAU—*Continued*

DIETITIANS—(a) Chief; general hospital currently under construction; will have collegiate affiliations, 250-beds; completion October; key personnel now being selected; university city, south. (b) Chief; university hospital, plans completed for new medical center including 500-bed hospital, medical school. (c) General hospital, 150-beds; residential town near Seattle. (d) Research hospital; formerly luxurious hotel; winter resort, south. MH3-4

DIRECTORS OF NURSING—(a) Dean, program for graduate nurses only; preferably one with doctoral degree. (b) Voluntary general hospital, 400-beds; 180 students; collegiate affiliations; $8-$10,000. (c) General hospital, 300-beds, currently under construction; key personnel now being selected; attractive residential town, near coast, southeast; $8000. (d) Fairly large general hospital; 170 students; interesting city outside United States; although tropical country, mild pleasant climate. (e) Beautiful new hospital, 300-beds; staff of outstanding specialists, faculty members, medical school; university and resort city. (f) General hospital, 200-beds; well endowed, foreign city; knowledge of Spanish or French requested. (g) Nursing service; general hospital, 350-beds; New England; $6000-$8000. (h) Nursing service; new 7½ million dollar hospital; unit, university group; west. MH3-5

EXECUTIVE HOUSEKEEPERS—(a) University hospital now under construction, 450-beds; completion September; man preferred. (b) New 100-bed hospital to be opened April 1st; college and resort town, southwest. (c) General 450-bed hospital, unit, university group; large city, medical center, east; substantial salary including maintenance. MH3-6

MEDICAL BUREAU—*Continued*

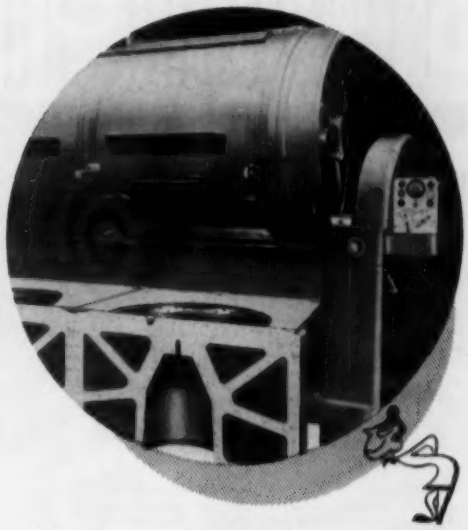
FACULTY POSTS—(a) Pediatric, maternity and nursing arts instructors; beautiful modern hospital; general, 400-beds; 170 students, mostly Orientals; attractive city outside United States. (b) Educational director; 425-bed general hospital; $5500-$6600; New England. (c) Assistant director of nursing education and clinical instructor in operating room work; San Francisco area. (d) Assistant nursing arts instructor and assistant instructors in medical-surgical, obstetrical and pediatric nursing; collegiate school; college town, midwest; $4500-$5000. (e) Educational directors for Iran, Iraq, Eritrea, instructors in pediatrics for Brazil, India, psychiatric for Brazil, pediatric and obstetrical for Guatemala, public health and tuberculosis for Panama. MH3-7

MEDICAL RECORD LIBRARIANS—(a) Chief; university hospital; plans completed for new medical center including 500-bed hospital, medical school. (b) Assistant; voluntary general hospital, 350-beds; suburban location, Southern California. (c) Chief; qualified to re-organize department, 400-bed hospital; unit, university group; medical center, east; attractive proposition. MH3-8

EXECUTIVE PERSONNEL—(a) Chief accountant qualified to direct business office; 250-bed hospital currently under construction; completion October; key personnel now being

(Continued on page 232)

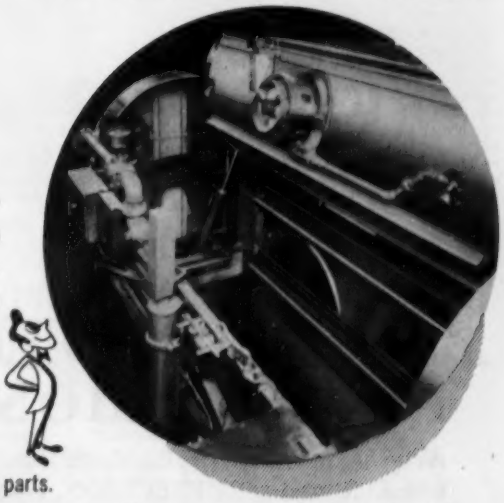
raise the cylinder



Below. Shell and cylinder shown in raised position. Note complete accessibility of all working parts, including dump valve, to permit rapid maintenance.

see for yourself why HOFFMAN surpasses all others for ease of maintenance

Other unloading washers *may claim* to increase your laundry production . . . but only HOFFMAN can deliver this promise. That's because HOFFMAN'S simplified design *makes maintenance easy . . . speeds adjustments*—goes back into service quickly to keep right on increasing your production for the same floor area.



Below. Close-up of V-belt and chain drive, for washer drive. Ultra-simple to adjust and repair.

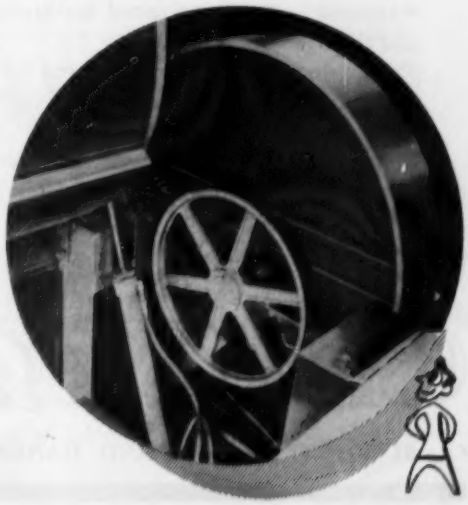
check these exclusive HOFFMAN features:

- ✓ Every part of the washer is within easy reach.
- ✓ Hydraulic raising of shell and cylinder quickly uncovers all working parts.
- ✓ Simple V-Belt and chain drive . . . provide effective transmission.
- ✓ Hoffman has fewer moving parts than any other washer.
- ✓ One knob controls all operational stages.
- ✓ Minor repairs can be made without disassembly.

ONLY HOFFMAN combines these unique features *with fast, automatic unloading* . . . designed to save manpower, pulling time, wear and tear on your linen.

Compare the HOFFMAN 42" with other unloading washers and you will join economy-wise institutional laundries who have selected HOFFMAN to get *all the benefits of increased sustained production.*

Available in three sizes with 225, 350 and 400 lb. capacities. Write for bulletin A-851.



U. S. HOFFMAN
MACHINERY CORPORATION

105 FOURTH AVENUE, NEW YORK 3, N. Y.

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

selected; college town, south. (b) Purchasing director; new 300-bed hospital; Canada. (c) Food service manager; 250-bed hospital; staff includes therapeutic dietitian; coastal city, south. MH3-9

STUDENT HEALTH—(a) Social director; new 350-bed hospital and affiliated clinic, 26 Board men; duties include counseling; east. (b) Liberal arts college; September 1955; south. MH3-10

STAFF AND SURGICAL—(a) Two staff; one of larger towns, Alaska. (b) Staff and surgical; fairly large hospital; Southern California. (c) Surgical; leading hospital; attractive section of Chicago; $300. (d) Staff and surgical; Japan. MH3-11

SUPERVISORS — (a) Obstetrical; 475-bed general hospital; collegiate affiliations; 65-bed obstetrical unit; residential town, short distances, several large cities, east. (b) Operating room; voluntary general hospital, 350-beds; service mainly surgical; medical center, midwest; $5000. (c) Medical-surgical; important hospital; San Francisco area. (d) Thoracic surgery; new department, 400-bed hospital, affiliated university; educational opportunity; minimum $4000; east. (e) Night; small general hospital; university town, midwest; opportunity continuing studies. (f) Operating room, obstetrical, pediatric and psychiatric; beautiful modern hospital; expansion program recently completed; resort city, south. MH3-12

ADMINISTRATORS—(a) Lay; general hospital 600-beds, medical school affiliation; west coast. (b) Lay; assistant; newly created post; 700-bed general hospital, medical school affiliation; opportunity succeed present administrator, 2 years; to $11,000; large city. (c) Lay; voluntary general hospital 450-beds; medical school affiliation; unit important medical center; east. (d) Medical; medical school affiliation voluntary general hospital 375-beds; large city; east. (e) Assistant; voluntary general hospital, 250-beds; approved JCAH; $7200; city 500,000; university medical center; midwest. (f) Lay; voluntary general hospital 150-beds; lovely residential college town; opportunity pleasant living; middle east. (g) Lay or medical assistant; one of south's important teaching hospitals; attractive city. (h) Medical director; very large general voluntary hospital affiliated several medical schools; outstanding faculty; large city. (i) Lay; 100-bed modern general hospital; resort area; Pacific northwest. (j) Administrative assistant; prefer one with Masters Hospital Administration; large teaching hospital, 750-beds; university city; midwest. (k) Lay, 125-bed general hospital; large city; southwest. (l) Administrative director 370-bed general hospital; requires sound background hospital work; university city, 500,000. (m) Lay; small general hospital; lake resort region; Florida. (r) Lay; general hospital 160-beds; excellent facilities; desirable university town 200,000; midwest.

ADMINISTRATIVE EXECUTIVE POSTS—(aa) Chief accountant; new general hospital 250-beds; opportunity advance to assistant administrator; fast growing industrial area 50,000; Canada. (a) Accountant; 300-bed general hospital; about $5000; fairly large college town; midwest. (c) Business Manager; 9 man group; air conditioned clinic; lovely town near Chicago. (d) Business Manager; male or female; small general hospital; to $6000; university medical center, 600,000; midwest. (f) Comptroller; new hospital, 200-beds, opening October; work under outstanding administrator; excellent board; town 100,000; south. (h) Comptroller; 250-bed voluntary general hospital affiliated medical school; city 100,000; east coast. (i) Office manager; experienced credit and collections work; 125-bed voluntary general hospital; consider male or female to age 50; scenic town 25,000; midwest. (j) Personnel director and admitting officer established new department; 350-bed general hospital; college town; southeast. (k) Personnel and public

(Continued on page 234)

GEORGIA BAPTIST HOSPITAL, Edwin B. Peel, Administrator
Stevens and Wilkinson, Architects
Henry C. Beck Company, Contractor

SAFETY *with an 18.7% annual return!*

Effective protection against fire can be achieved with an automatic sprinkler system. Records of the National Fire Protection Association for a 10 year period reveal not one loss of life in 160 fires in hospitals having sprinklers. Contrast that with *unsprinklered* hospitals. Here, the record is shocking. Of 58 fires in *unsprinklered* hospitals, there were 226 deaths.

In an address before the 1954 session of the Southeastern Hospital Conference, the following statement was made by Mr. George E. Linney, Assistant Administrator, Georgia Baptist Hospital, Atlanta.

"Early in 1947 the Georgia Baptist Hospital installed a Grinnell Sprinkler System in its surgical building (now the west wing of the main building), also a similar system in a large nurses' residence. In 1952 the service building, including a warehouse, laundry, and repair shops, was protected by Grinnell Sprinklers. *The reduction in fire insurance was gratifying.*"

Mr. George E. Linney
Assistant Administrator
Georgia Baptist Hospital, Atlanta

For example (the figures are Mr. Linney's) . . .

Total Area Protected	Cost of Sprinkler Systems	Annual Savings in Insurance	System pays for itself in
108,000 sq. ft.	$27,792	$5,205.49*	5.34 years

**Represents 18.7% annual return on investment in Grinnell Sprinkler protection.*

Mr. Linney adds . . . "Sprinkler installers cooperated to minimize disruption in daily routine. 'Business as usual' was carried on during the installation of the system."

Other hospitals, too, report on both the efficiency of Grinnell Sprinklers, and Grinnell installation crews. Why delay getting the complete facts? Grinnell will gladly outline a fire protection program for you, without obligation. Write Grinnell Company, Inc., 255 West Exchange Street, Providence, Rhode Island.

GRINNELL
PROTECTION AGAINST EVERY FIRE HAZARD

Manufacturing, Engineering and Installation of Automatic Sprinklers Since 1878

classified advertising

POSITIONS OPEN

WOODWARD—*Continued*

relations; 455-bed general hospital; medical and cultural center; midwest. (j) Purchasing director; hospital experienced; consider male or female; 250-bed general hospital; town 80,000, southeast.

ADMINISTRATORS—Women. (a) Lay or RN; 75-bed general hospital; to $6500; town 20,000 near university city; southwest. (b) Lay or RN; new hospital, construction to begin shortly; 40-beds; attractive small town; midwest. (c) Lay or RN; 50-bed general hospital; Florida. (d) Lay or RN; experienced; general hospital 150-beds; university city; southwest. (g) RN; to revise and develop university nursing curriculum; to $7500; large university city; midwest.

ANESTHETISTS—(a) Chief; excellent equipment, active surgical service; 150-bed general hospital; attractive town 20,000; southeast. (b) By 4-man clinic group; resort town; south central. (c) 250-bed voluntary general hospital; 3 other anesthetists and M.D. in department; Smoky mountains. (g) General hospital 100-beds; $550; attractive town; Pacific northwest.

DIETITIANS—(a) Chief; very large voluntary general hospital; New England. (b) Chief; 100-bed orthopedic hospital; attractive resort town; southwest. (c) Therapeutic; fully approved 200-bed general hospital; $375 start; city 200,000; middle east. (e) New 350-bed university hospital, opening soon; California. (f) Chief; new 120-bed general hospital; attractive college town 25,000; southeast.

DIRECTOR OF NURSES—(aa) Nursing service and education; 100 students, college affiliated school; large fully approved general hospital; to $10,000; attractive city 200,000; middle east. (a) Nursing service; 250-bed tuberculosis hospital; to $6000, full maintenance; attractive city; east. (b) Nursing service and education; 300-bed general hospital; 90 students; excellent staff and facilities; about $8000; California. (c) Nursing service; approved 150-bed general hospital; attractive city; Michigan. (d) New 300-bed general hospital, opening July; to $7000; desirable city; south. (e) Nursing service; 75-bed general hospital, opening shortly; attractive resort town; Florida. (f) Nursing service and education; fully approved 200-bed general hospital; collegiate affiliated school; faculty rank; town 30,000; northwest.

EXECUTIVE HOUSEKEEPERS—(a) New 225-bed general hospital; excellent facilities; residential suburb university medical center; middle east. (b) Very large university hospital; desirable city; Pacific northwest. (c) Supervise staff of 40 employees; large pediatric and maternity hospital, university affiliated; east.

FACULTY POSTS—(a) Educational director; responsible only to administrator; 45 students; approved 200-bed general hospital; to $7500; lovely town 20,000; east. (b) Instructor in nursing arts, pediatrics and obstetrics; large general hospital; Hawaii. (c) Educational director; potential 200 students; large teaching hospital; to $6600; New England. (d) Assistant educational director; 500-bed university hospital; desirable town 100,000; south.

SUPERVISORS—(a) Various departments; 100-bed general hospital opening soon; town 30,000; southwest. (b) Obstetrical; 45-bed unit; large general hospital; university city; middle east. (c) Operating room; administrative ability required; 8 room suite; 300-bed general hospital; California. (d) Operating room; 400-bed teaching hospital primarily surgical; excellent facilities; university city; widwest.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—(a) 200-bed hospital, Florida; $10,000. (b) 135-bed hospital Pennsylvania. (c) 30-bed hospital, western Pennsylvania. (d) 80-bed hospital for incurables, east. (e) 50-bed Illinois hospital. (d) 125-bed hospital, west.

ADMINISTRATIVE ASSISTANT—(a) 200-bed eastern hospital. (b) Credit-office manager; 150-bed hospital, New York State. (c) Accountant; 400-bed Ohio hospital.

(Continued on page 236)

classified advertising

POSITIONS OPEN

INTERSTATE—*Continued*

NURSE ADMINISTRATOR—(a) 80-bed chronic hospital, east. (b) 30-bed hospital, west. (c) New hospital, Iowa.

DIRECTORS, NURSING SERVICE—$4500-$6000.

EDUCATIONAL DIRECTORS — Instructors, nursing arts; clinical supervisors; to $5000.

DIRECTOR, School of Nursing—(a) 200-bed midwestern hospital; university city. (b) 300-bed Ohio hospital. $6500. (c) 250-bed hospital, south central state; open July.

RECORD LIBRARIAN—(a) 400-bed University hospital; west; excellent salary. (b) 275-bed hospital, Michigan. (c) 175-bed Ohio hospital; $350. (d) 180-bed hospitals, New York, Connecticut, Maryland, Florida.

EXECUTIVE HOUSEKEEPER—(a) 200-bed New Jersey hospital. (b) 285-bed hospital, Massachusetts. (c) 215-bed modern hospital, new, midwest; to open summer 1955. (d) 200-bed hospital, Pennsylvania. (e) 225-bed hospital, modern building, Ohio. $325.

TECHNICIANS, LABORATORY—(a) 100-bed Ohio hospital; $350. (b) Bacteriologist; Ohio; $425. (c) Laboratory and x-ray technicians; $300-$350. Midwest; southwest.

SHAY MEDICAL AGENCY

Blanche L. Shay, Director

55 East Washington Street

Chicago 2, Illinois

DIRECTORS OF NURSING—(a) Middle west; 425-bed hospital; 36 month school of nursing program; average enrollment about 95; $8000-$10,000. (b) East; 100-bed hospital; nursing school accredited; enrollment averages 45; $6000 plus maintenance. (c) South; 225-bed hospital in city of 25,000; close to seashore and mountains. $7200. (d) Middle west; 100-bed hospital with expansion program under way to increase to 200-beds; excellent staff; no nursing school; $7200. (e) East; 210-bed hospital located in city of 50,000; new nursing home; $6000-$7200 plus a very nice suite of rooms.

DIETITIANS—(a) Chief; middle west; 125-bed hospital in pleasant community of about 20,000; dietary department is completely new with all modern facilities; $5400. (b) Assistant; east; 500-bed hospital; 100 in department; $4800. (c) Therapeutic; 325-bed hospital; some teaching; 4 in therapeutic department; $4200. (d) South; administrative; 500-bed teaching hospital 130 employees in department food service decentralized $6000. (e) West; 250-bed general hospital, fully approved; 45 employees in department; duties: instruction of student nurses and supervision of special diet kitchen; $4800. (f) A food management organization has taken over the dietary departments of quite a few

(Continued on page 238)

SHAY—*Continued*

hospitals and needs dietitians to supervise the dietary service in each individual hospital; positions offer excellent salaries, congenial associates and unlimited opportunity for advancement; salary to $6500.

PHARMACISTS—(a) West; chief; 150-bed general hospital; expansion to 200-bed almost completed; pharmacy is completely new and modern. $525. (b) East; chief; 225-bed general hospital, fully approved. $450. (c) Middle west; 175-bed hospital located in pleasant community close to several large cities; $400. (d) Middle west. 350-bed hospital in university town; 4 in department; $400. (e) East; 150-bed hospital ideally located in beautiful resort area; duties will also include supervision of central stores and purchasing; $6500.

INDIANA MEDICAL BUREAU

212 Bankers Trust Building

Indianapolis, Indiana

ANESTHESIOLOGIST — Associate, 160-bed western hospital, partnership in near future.

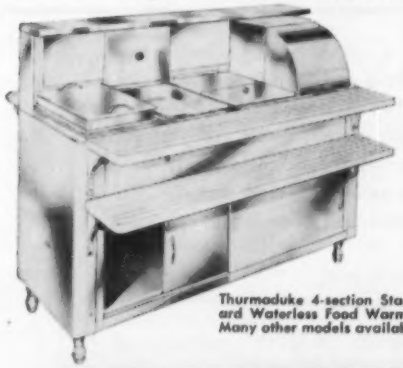
ANESTHETISTS—(1) 250-bed Michigan hospital, 40 hour week; $400 month, additional for on call; can live in. (2) 100-bed northwestern hospital, 40 hour week, $450 month, additional for on call.

for more efficient food service...

BETTER DO WHAT BOEING DID

Seven thousand people a day pass through this ultra-modern *Boeing Airplane Cafeteria* at Wichita, Kansas. The eight Thurmaduke Standard Unit Counters total more than 400 feet in length.

This efficient and beautiful set-up includes many exclusive Thurmaduke features designed to provide better tasting food at lower cost with less maintenance.



Thurmaduke 4-section Standard Waterless Food Warmer. Many other models available.

Whether you require a ten foot counter, a thousand foot counter, or a separate food warmer . . . you can do what Boeing did for more efficient food service. You can depend on Thurmaduke for unmatched engineering excellence backed by 51 years of manufacturing experience.

Clip and Mail Today

DUKE MANUFACTURING CO. Dept. MH-3
2305 NO. BROADWAY, ST. LOUIS 6, MO.

Please send complete information on
☐ Cafeteria Counters ☐ Waterless Food Warmers

NAME_____

ADDRESS_____

CITY AND ZONE_____ STATE_____

THURMADUKE

DEPENDABLE FOOD SERVICE EQUIPMENT

THURMADUKE WATERLESS FOOD WARMERS • STANDARD UNIT COUNTERS AND OTHER EQUIPMENT

classified advertising

POSITIONS OPEN

INDIANA—*Continued*

RADIOLOGISTS—(1) 250-bed midwestern hospital, large city. (2) Group practice, southwest location. (3) Group practice, midwestern location. (4) 250-bed midwestern hospital in state capital.

PSYCHIATRIST—Male, start as associate; prefer certified or eligible.

MEDICAL TECHNOLOGISTS—(1) Small west coast hospital, $375 to $500. (2) Small eastern hospital, salary and maintenance. (3) Bacteriologist, M.S. degree, midwestern pharmaceutical house. (4) Registered laboratory & x-ray combination; 60-bed South Atlantic seaboard. (5) Laboratory & x-ray combination, small northwestern hospital.

NURSING POSITIONS—(1) Dean for western university; must have doctoral degree. (2) Director, 200-bed western hospital, responsible for both nursing & education, about $6000. (3) Director, small west coast hospital. (4) Director, small Indiana hospital. (5) Associate director, nursing education, Master's Degree required. (6) Director, new 250-bed eastern hospital.

PHYSICAL THERAPISTS—(1) Chief, supervise 8, 100-bed midwestern hospital. (2) Chief, 116-bed southern hospital.

INDIANA—*Continued*

DIETITIANS—(1) Chief, 250-bed midwestern hospital, near large metropolis. (2) Chief, 250-bed midwestern hospital; recent graduate acceptable. (3) Chief, 250-bed Indiana hospital. (4) Assistant, 250-bed eastern hospital. (5) Chief, 400-bed eastern hospital.

EXECUTIVE HOUSEKEEPER—for 200-bed Indiana hospital, female, age 35-50 preferred.

PLACEMENT BUREAUS

HOSPITAL PERSONNEL BUREAU
Knickerbocker Bldg. 218 E. Lexington St.
Baltimore 2, Maryland
"LExington 9-5029"

Chas. J. Cotter, Director
(Former Administrator)

Nation-wide placement service for Physicians, Administrators, Anesthetists, Dietitians, Nurses, Technicians, Pharmacists, Comptrollers, Accountants, Secretary, Housekeepers, etc.

Mail resume, 5 photos, salary.

No Registration Fee. Licensed Employment Agent.
(formerly Hagerstown, Maryland)

(Continued on page 240)

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES

11 West 42 Street New York 36, N. Y.

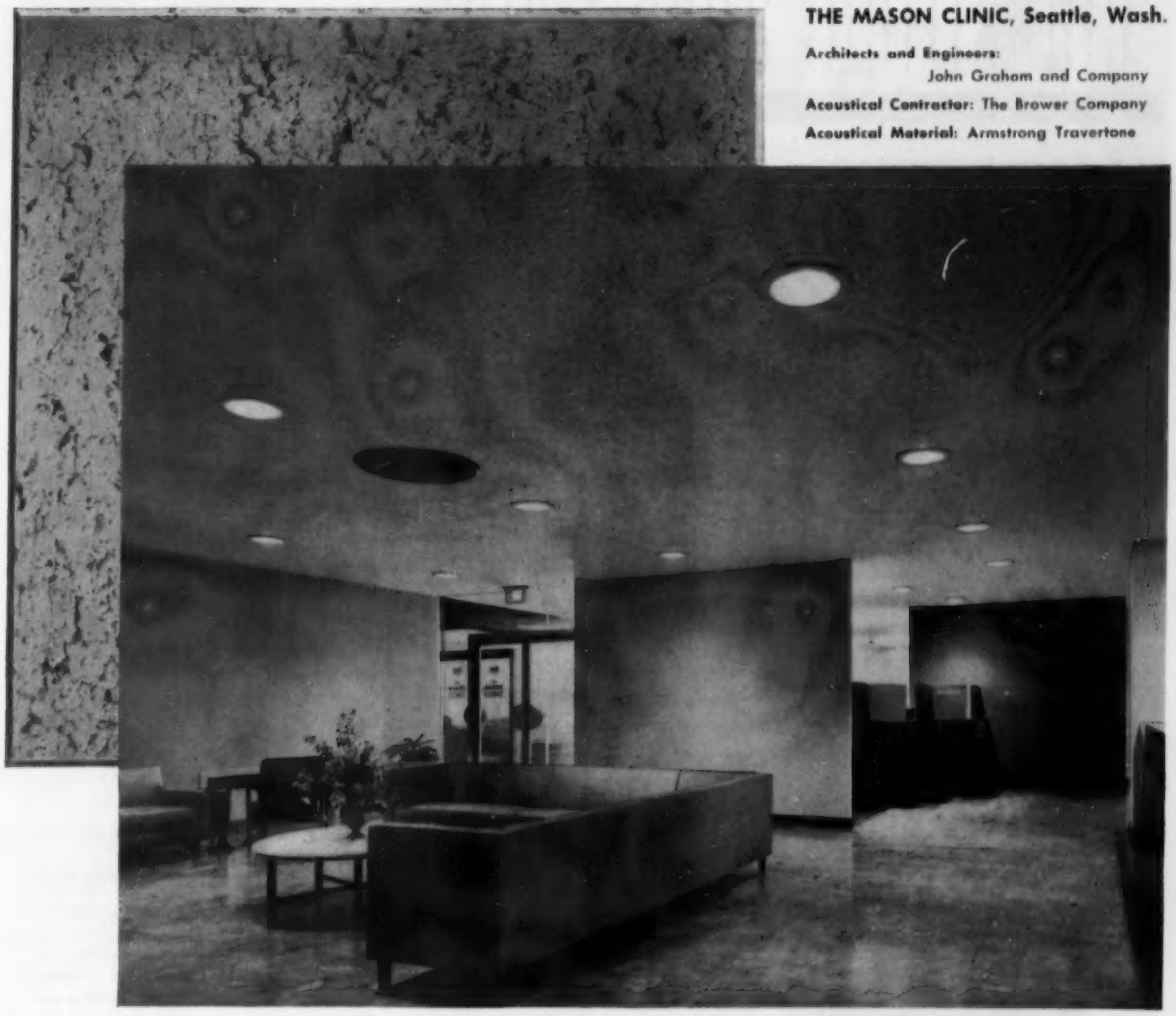
Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee
Agency



THE MASON CLINIC, Seattle, Wash.

Architects and Engineers:
John Graham and Company

Acoustical Contractor: The Brower Company

Acoustical Material: Armstrong Travertone

This ceiling provides quiet . . . beauty . . . safety

Sound-conditioned ceilings are expected to work triple time in Seattle's Mason Clinic. That's why Armstrong Travertone was chosen as the acoustical treatment. First, Travertone* soaks up noise, maintaining the quiet necessary to a hospital. Second, its distinctive appearance adds dignity and smartness to the décor. And finally, Travertone's incombustible composition provides an extra measure of fire protection.

Muffles sound . . . Travertone's mineral fiber composition soaks up as much as 80% of the noise that strikes it. Extremely high efficiency keeps noise from rebounding and building up to disturbing levels.

Adds beauty . . . A handsomely fissured surface gives Travertone the smart appearance of travertine marble. Its two-coat white paint finish has high light reflectivity. If desired, Travertone can be repainted to match any particular color scheme.

Incombustible . . . Made of mineral wool fibers, Travertone is rated completely fire-safe and acts as an effective fire-stop. Travertone meets even the strictest building codes.

Easy to maintain . . . Upkeep of a Travertone ceiling is easy and economical. It can be washed or repainted whenever desired without impairing its acoustical efficiency.

Get the full story on Travertone and the entire line of Armstrong sound-conditioning materials from your Armstrong Acoustical Contractor. For your free copy of the new 1955 edition of "Armstrong Acoustical Materials," write Armstrong Cork Company, 4203 Union Street, Lancaster, Pennsylvania.

* Trade-Mark

Armstrong

ACOUSTICAL MATERIALS

Cushiontone® • Travertone • Minatone®

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PLACEMENT BUREAUS

THE MEDICAL FIELD
EMPLOYMENT AGENCY

790 Broad Street—cor. Market
Newark 2, N.J.
Mitchell 2-1940, 1941

A MEDICAL AGENCY specializing in placements for Industry, Pharmaceutical Houses, Doctors' Offices and Institutional help.

Eleanor M. Mangini, R.N.
Director

MEDICAL PLACEMENT SERVICE
Mrs. Stewart R. Roberts, Director

15 Peachtree Place, N. W.
Atlanta, Georgia

Southern Hospitals look to us for personnel. We have openings for Nurse Anesthetists, Laboratory Technicians, Nursing Directors, Dietitians. Let us help you locate the opportunity you are seeking.

PLACEMENT BUREAUS

THE ABBOTT REFERENCE REGISTRY
Box 26, Hobart, Indiana

—a lifelong reference service to professional and technical personnel.

Because the Registry does not charge a fee for placement, employers feel added confidence in its service. Safeguard your references by establishing a permanent professional file. A respected supplement to every placement activity. Send for brochure.

ZINSER PERSONNEL SERVICE
Anne V. Zinser, Director

Suite 1004—79 West Monroe Street
Chicago 3, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

(Continued on page 242)

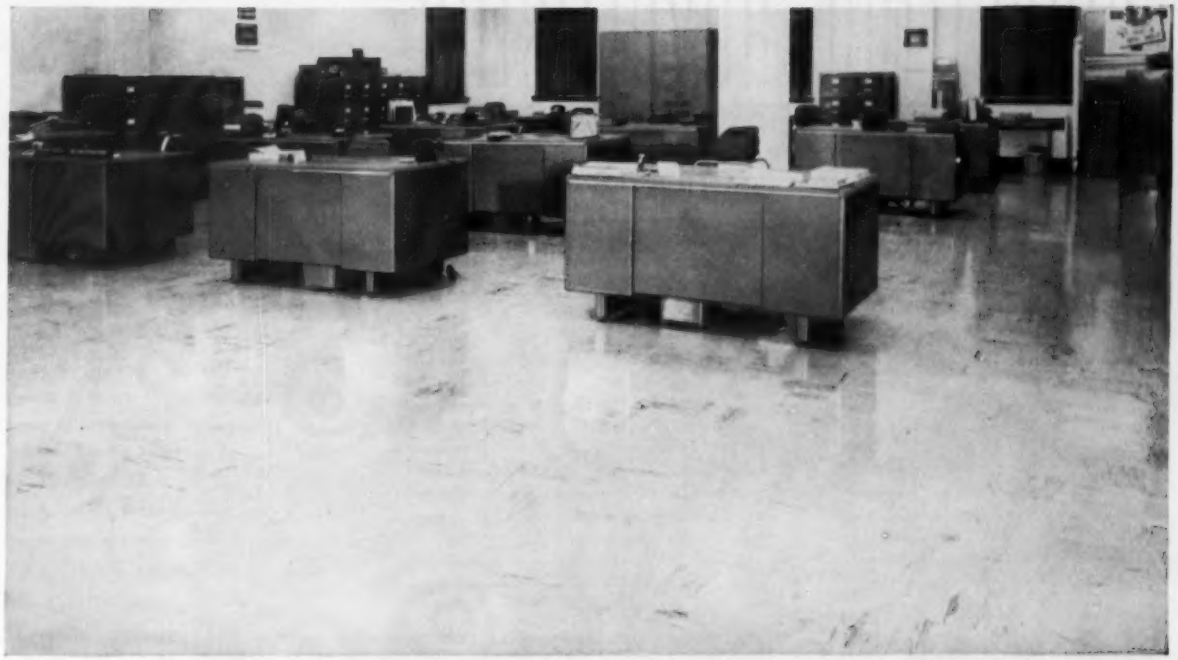
MISCELLANEOUS

DIRECTOR OF NURSING—360-bed hospital, diploma school of nursing, must have both educational and administrative training and experience; salary commensurate with qualifications; position available immediately; will also need Educational Director and several Clinical Instructors for fall term in pediatrics and obstetrics. Apply The Queen's Hospital, P. O. Box 614, Honolulu, Hawaii.

HOSPITAL FACILITIES CONSULTANT—Responsible for Hill-Burton and Territorial construction programs, cooperation with Alaska Public Works construction program, and hospital licensing program. College graduation plus four years of progressively responsible governmental or business experience, of which two years will have been in an administrative or consultative capacity related to public health or hospital administration. Salary open. Write C. Earl Albrecht, M.D., Alaska Department of Health, Juneau, Alaska.

FOR SALE

2—Scanlon-Morris, Ohio Chemical Co. Cat. No. 3292, Serial No. 8 "Opray" Multi-Beam, Explosion Proof, Portable Operating Room Lamps. Made for use in rooms where ceiling lamps cannot be installed because of height or other conditions. Due to revision of original plans, these lamps were never put into use. Will sell at 50% of original cost. FOB Cleveland. Reply FS 12, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.



Protect and Beautify your Floor with MULTI-CLEAN WAXES

WATERPROOF WAX

Hard, tough finish defies water, wear and scuffing

Multi-Clean WATERPROOF FLOOR WAX (both "regular" and "anti-slip") gives your floors a lustrous, long lasting, anti-slip finish.

It's a money saver, too . . . for its exceptional durability and the ease with which it is applied allows you to make important savings in both material and labor. Dries hard and waterproof in 15-20 minutes under normal conditions.

The finest North Country Carnauba gives Multi-Clean WATERPROOF WAX an extremely hard, yet *resilient* surface that enables it to stand up under severest wear in schools, office buildings, public institutions, shops, stores, warehouses, show rooms, halls, apartment buildings and homes. Recommended for all types of floors including wood, concrete, terrazzo, linoleum, rubber and asphalt tile.

ANTI-SLIP FOR SURE FOOTING

Underwriters' Laboratories have approved both Multi-Clean ANTI-SLIP WATERPROOF WAX and regular WATERPROOF WAX for all types of floors.

DEEP GLOW WAX

Self-polishes to a bright, clear gloss. Water resistant

Multi-Clean DEEP GLOW WAX, with its high resistance to water, is also recommended for all types of floors. It is especially suited for heavy traffic areas because it keeps its high lustre despite repeated moppings, water spotting and tracked-in mud or slush.

For any type of floor and under any traffic conditions, you can count on DEEP GLOW to give your floors the most beautiful self-polishing protective finish they've ever had! One coat applies easily and dries quickly to a high gloss. Rubber burns and scuff marks are readily buffed out.

Unlike other self-polishing waxes, Multi-Clean DEEP GLOW is almost colorless. This makes it the ideal choice for light-colored floors.

MULTI-CLEAN PRODUCTS, INC. Dept. MH-35
2277 Ford Parkway, St. Paul 1, Minnesota

Gentlemen: I'd like floor maintenance information on: ☐ Concrete, ☐ Asphalt tile, ☐ Terrazzo, ☐ Wood, or _____. Also literature on: ☐ Floor Machine, ☐ Scrubbing Machine, ☐ Industrial Vacuum Cleaner.

Name _____ Title _____

Address _____

City _____ Zone ____ State _____

classified advertising

FOR SALE

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We have in stock *every* nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

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X-Ray, physiotherapy, hospital and laboratory equipment, new, used and surplus. Tell us what you need. Your inquiries promptly acknowledged. MEDICAL SALVAGE CO., INC., 217 E. 23rd Street, New York 10, N.Y.

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Ill.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

ST. LOUIS CITY HOSPITAL SCHOOL OF NURSING offers to graduate nurses supplementary courses of three months in medicine and surgery and all specialties.

For further information write Director, School of Nursing, St. Louis City Hospital, 1515 Lafayette Avenue, St. Louis, Missouri.

Graduate Hospital of the University of Pennsylvania offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Tuition fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

Your floor makes a

Grand Entrance

with Flexachrome!

Dress up your entrance, lobby or waiting room...quickly, easily and at moderate cost... with Flexachrome Vinyl Plastic-Asbestos Tile.

Flexachrome is as versatile as your imagination. It will give you just about any floor design or color scheme you want. You have 23 unusually smart, brilliant colors to choose from . . . a wide range of sizes . . . custom-made inserts . . . tile-at-a-time installation.

As far as wearing ability is concerned, you get more "mileage" out of Flexachrome than you ever thought possible.

Flexachrome is greaseproof and highly resistant to scuffs, acids and alkalies. And its tight, smooth close-textured surface makes it easy to keep clean. Just daily sweeping and periodic washing is all that is necessary.

This beautiful floor tile can pay for itself in maintenance savings!

Get in touch with your Tile-Tex Contractor for complete specifications and samples, design and layout assistance. You'll find him in the local classified telephone directory. Or write:

THE TILE-TEX DIVISION, The Flintkote Company, 1234 McKinley Avenue, Chicago Heights, Illinois

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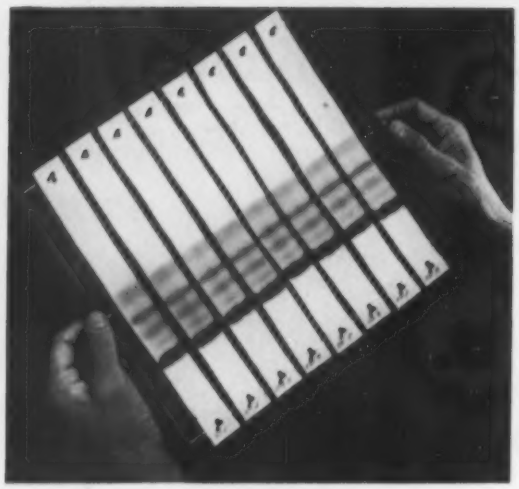
Manufacturers of Flexachrome*... Tile-Tex*... Tuff-Tex*... Vitachrome*... Holiday†...Mura-Tex* ...and Modnar†, the newest development in asphalt tile.

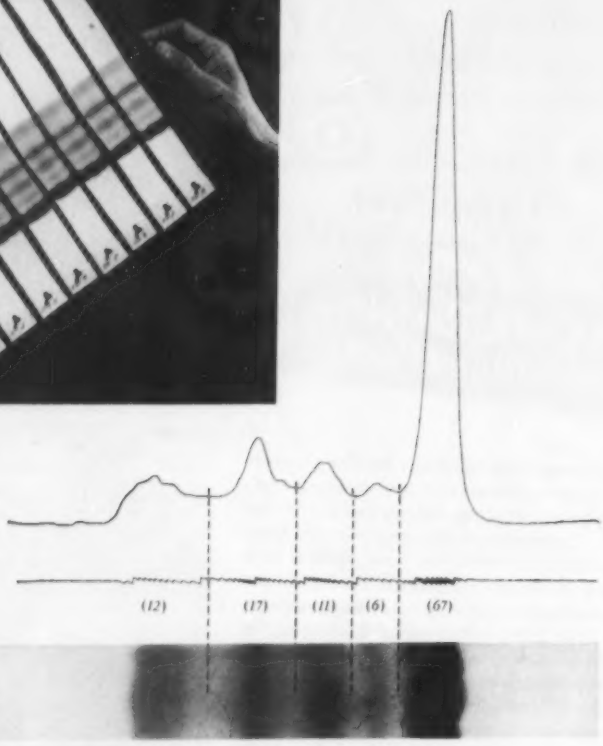
Coming In April . . .

- An interesting review of the administrative and public relations problems which arose when Bing Crosby entered St. John's hospital in Santa Monica.
- An informative article on collections which tells how to be businesslike and efficient yet considerate and not strictly dollar minded.

See

The Modern Hospital
919 N. Michigan Ave., Chicago 11, Ill.





RESULTS • *reproducible - rapid* • *automatically recorded*

NEW SPINCO Model R PAPER ELECTROPHORESIS

For the first time, a complete paper electrophoresis system with coordinated features for simple routine analyses in the clinical laboratory. Every step is systematized from precision application of the specimen to final automatic recording of the relative concentrations. Ask for full details.

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BELMONT 2, CALIFORNIA

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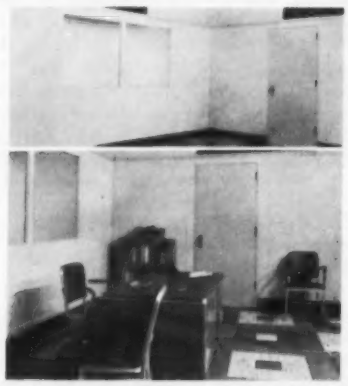
WHAT'S NEW FOR HOSPITALS

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 264. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it

Movable Walls Are Incombustible



Johns-Manville Class A Movable Walls make it possible to re-arrange interiors according to need with minimum disturbance. They are incombustible, being made with an all mineral core with sturdy asbestos cement surface and steel trim. They are finished in a tough, hard, durable film which is mar and scratch resistant and rejects stain and soil. When necessary it can be easily washed and scrubbed and, if damaged, can be touched up inexpensively.

The walls are available in restful colors or in natural finish for decoration after installation. They are erected complete with doors, door hardware, glass and trim and are available in ceiling or free standing heights. They make attractive, finished walls which are movable when changes are desired. **Johns-Manville, 22 E. 40th St., New York 16.**

For more details circle #210 on mailing card.

Change of Tape Color Assures Sterilization

Change in color of Johnson & Johnson's new Tyloc Pressure-Sensitive Tape indicates sterilization of packs, bags, trays and tubes. The new Tyloc changes color from bright yellow to buff after sterilization by dry or steam heat. The color change does not affect ink, ball point pen, pencil or other labeling marks and the bright yellow background facilitates labeling. The new formula provides improved quick-sticking qualities and added shelf life. The new Tyloc tape is designed for use in fastening all types of packages for sterilization. **Johnson & Johnson, New Brunswick, N. J.**

For more details circle #211 on mailing card.

Close-Up Attachment for Medical Photography

A newly developed unit has been announced for use in medical photography. The new Kodak Technical Close-Up Outfit contains everything needed for close-up medical photography, including Kodak Pony 828 camera, flasholder and attachments. A second unit, known as the Kodak Technical Close-Up Kit, contains material for converting a Kodak Pony 135 or 828 camera to close-up use. Color transparencies of maximum quality can be produced with a minimum of difficulty by doctors and nurses inexperienced in photography when the new equipment is used. **Eastman Kodak Company, Rochester 4, N. Y.**

For more details circle #212 on mailing card.

Cubicle Curtain Track for Ceiling Installation

Adaptable to virtually any building plan or design, the new Judd extruded

aluminum alloy cubicle curtain track may be secured to conventional plaster or acoustical ceilings, surface or flush. It permits freedom of room planning since its use need not interfere with lighting fixtures, doorways or window arrangements. The new track provides custom-fabricated one-piece bends for trim appearance and complete reduction of noise when curtains are drawn.

In the new type track, carrier wheels traverse on the track level, preventing the carrier from twisting or jamming, reducing wheel drag and noise and ensuring easy, trouble-free operation. A special nylon double-wheeled carrier with self-lubricating action is used with the track, eliminating the use of metal bushings and metal-to-metal contact. Curtains with nylon mesh headers for full ventilation even when the curtains are closed are also available. **H. L. Judd Division, The Stanley Works, 87 Chambers St., New York 7.**

For more details circle #213 on mailing card.

(Continued on page 248)

Plastic Surfacing in 46 Patterns

Decorative plastic surfacing in 46 patterns and colors is offered in the new Consoweld 10 and Consoweld 6. Tested by the Color Research Institute of America, the patterns and colors are designed to provide walls and equipment for any color scheme. Consoweld 10 is a plastic surfacing which is easily applied to both vertical and horizontal surfaces and can be used over plaster walls, gypsum lath, sheathing grade plywood or over cinder blocks and cement. Consoweld 6 is used on furniture, doors, fixtures, cabinets and other equipment for both horizontal and vertical surfaces. Both products give a durable finish which resists wear and abuse and is attractive. **Consoweld Corporation, Wisconsin Rapids, Wis.**

For more details circle #214 on mailing card.

Year-Round Air Conditioning With Unarco "Dual-Vector"

Year-round air conditioning is now possible at a low price with the new Unarco "Dual-Vector" hot and chilled water heating and cooling system. It can be easily installed in existing wet-heat structures as well as in new buildings and provides a completely flexible system of balanced air conditioning for any sized room. Winter dirt and summer pollen are trapped in the filters and clean, quiet, even heat is provided in winter with cool, dehumidified air in summer. A unit fan control permits individual room temperature and humidity capac-

ities which can be operated thermostatically or by manual settings. **Union Asbestos & Rubber Co., Heating and Cooling Div., 332 S. Michigan Ave., Chicago 4.**

For more details circle #215 on mailing card.

WHAT'S NEW

Motor-Driven Hilow Bed Approved for Use With Oxygen

The new Model No. 62 Hill-Rom motor-driven high-low patient bed has approval of Underwriters' Laboratories for use with oxygen administering equipment of the nasal, mask type and half-bed length oxygen tents, according to an announcement from the manufacturer. The new adjustable height bed has the motor and switch box at the foot end and is designed so that Hill-Rom Safety Sides can be used on it when required. The motor and gear reduction unit are designed and rated for long service life under constant use. The bed may be raised for patient care, lowered for patient comfort and convenience, or stopped at any intermediate position by turning the switch when it reaches the desired height. It stops automatically when reaching the maximum high and low limits. **Hill-Rom Company, Inc., Batesville, Ind.**

For more details circle #216 on mailing card.

Accurate Heating Record With Heat Recorder-Totalizer

Accurate information on operation of the heating system is possible with the new Heat Recorder-Totalizer. All operations of the heating system are recorded automatically on a continuous, permanent record which moves through the machine at a steady rate. The time the heat goes on, how long it is on, when it goes off, and other data are recorded automatically. A built-in time totalizer keeps the record up to date constantly. The administrator and the engineer will find the instrument invaluable in keeping accurate records.

The Heat Recorder-Totalizer can be

easily installed in any heating system, old or new, large or small, and is electrically operated. It requires no service or adjustment and can be read at any time. The tape record can be left to accumulate or can be torn off for study and filing. **Heat-Timer Corporation, 657 Broadway, New York 12.**

For more details circle #217 on mailing card.

Utility Carts Have Steel Frame

A low-priced line of Lakeside Utility Carts is now available. Constructed of chrome-plated tubular steel, the carts have 15½ by 24 inch steel shelves with raised lips on all edges to keep supplies from slipping off. Carts have a carrying capacity of 100 pounds and move easily on ball-bearing swivel casters with rubber wheels. They are designed for use as medicine carts, dressing carts, laboratory carts, equipment carts, supply carts, dish carriers and for general utility use. **Lakeside Mfg. Inc., 1977 S. Allis St., Milwaukee 7, Wis.**

For more details circle #218 on mailing card.

Bedside Carafe Is Practical and Attractive

The attractive new Bolta Carafe is available in a series of decorator colors. The dual-purpose design provides a matching drinking cup which serves as a stopper for the carafe when not in use. The lightweight, break-resistant styrene plastic carafe holds two full cups of ice water or other beverages for bedside or tray use. It is impervious to beverage and food stains and may be washed in a mechanical dishwasher. The attractive colors include coral, turquoise, gray, bottle green and chartreuse. **Bolta Products, Lawrence, Mass.**

For more details circle #219 on mailing card.

Flatwork Ironer Offers High Speed

Increased speed is offered in the new Speedline Flatwork Ironer. Three design features which permit operating speeds up to 115 feet per minute include oversize 13⅜ inch rolls, greater chest area and operation on 125 pounds steam pressure. More flatwork can be processed better per hour at proportionately lower cost, according to the manufacturer.

(Continued on page 250)

Other new features incorporated in the ironer include tapered roller bearings on padded rolls and intermediate shafts re-

quiring infrequent lubrication; a pressure mechanism to protect padding when the ironer is not running by lifting the padded rolls off the chest, and the modern, low slung design for easier feeding and receiving of flatwork. **Troy Laundry Machinery Division, American Machine & Metals, Inc., East Moline, Ill.**

For more details circle #220 on mailing card.

Interior Wall Tile Reduces Costs

Keramet Ceramic Glazed Structural Facing Tile has been developed to reduce the cost of interior walls. It was especially engineered to meet the needs of construction budgets and rigid performance requirements. It has a gray speckled satin-mat finish that harmonizes with all decorative plans and assures good light reflectivity. Keramet has a first quality ceramic surface on genuine clay tile and comes in a simplified line of 6T Series Shapes to save design time. **Metropolitan Brick, Inc., Canton, Ohio.**

For more details circle #221 on mailing card.

Saddle Stapler Permits Stapling Wide Pages

Pages up to 12 inches in width can be stapled with the new B8S Saddle Stapler. The operating mechanism of the B8 stapler is mounted on a specially-formed saddle base with the clincher at the peak of the saddle. The back of the base is curved so that wide pages will roll up. The new stapler is easily loaded with a strip of performed staples with ¼ inch legs. It will staple booklets, folders, programs and other material from eight to 128 pages of medium weight stock. The front of the base has a rubber foot to

protect the desk top and keep the machine from sliding. The stapler is finished in black enamel and chromium. **Bostitch, 1019 Mechanic St., Westerly, R.I.**

For more details circle #222 on mailing card.

. . . and for
COLUMBIA PRESBYTERIAN HOSPITAL, NEW YORK
signal and communication systems so vital to hospital efficiency were designed and produced by

One nurse does the work of two in hospitals equipped with the new Auth VOKALCALL audio-visual nurses' call system. The nurse uses her VOKALCALL control board for two-way voice communication with the patients in her care. She can learn their needs and talk directly to them without leaving her station. VOKALCALL doubles the nurse's effectiveness, and saves her countless unnecessary trips to bedsides each day.
For literature that describes this and other types of Auth systems, write to:
Auth Electric Company, Inc.
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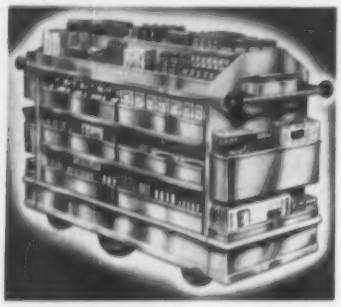
SIGNAL, TIME
and COMMUNICATION SYSTEMS

Auth

WHAT'S NEW

Gift Cart Is Versatile Unit

The new Crescent Gift Cart is extremely mobile and can be handled easily by one attendant even when fully



loaded. A neoprene rubber swivel caster in the front and rear and two large semi-pneumatic wheels in the center permit easy negotiation of narrow aisles and sharp corners. The cart is equipped with trays and cash box for use as a gift cart. When these are removed, it can be used as a mobile utility or supply cart or for storage of supplies.

The new cart is designed to provide an over-all display area as well as ample storage space and is available in two sizes. It has a rubber bumper around the bottom and rubber protectors on the handles to avoid marring wall or door surfaces. It is available finished in any of a variety of soft pastel colors. **Crescent Metal Products, Inc., 18901 St. Clair Ave., N.E., Cleveland 10, Ohio.**

For more details circle #223 on mailing card.

Electronic Air Cleaner in Institutional Sizes

Two new models of the Electro-air electronic air cleaner have been developed for institutional and commercial installations. The larger line is built to fit exact specifications so that institutions can install correctly sized electronic air cleaners in conjunction with heating and cooling plants. Known as the "Built-Up" unit, it is completely assembled and tested at the factory, then match-worked, disassembled and shipped in crates marked for easy erection. The all aluminum framework eliminates the possibility of rust, thus minimizing maintenance.

The second model is the "Custom-Line" unit. This packaged air cleaner is complete in a steel cabinet and is designed for use where space is limited. It is available in a number of sizes and may be floor mounted or suspended. The new models operate by ionizing dust, soot and pollen particles in the air stream and depositing them on aluminum plates where they are held until flushed away by washing manifolds. Pure, clean air is then ready for circulation through the heating or cooling system. **Electro-air Cleaner Co., 1285 Reedsdale St., Pittsburgh 33, Pa.**

For more details circle #224 on mailing card.

Disposable Syringes for Many Uses

A series of calibrated 2 cc sterile disposable syringes is now available for many hospital uses. An antibiotic syringe with detachable 20 by 1¼ inch needle, a syringe with 25 by ⅝ inch needle and a syringe without needle are among the disposable items in 2 cc capacity. All three are sterile and pyrogen-free, individually packed in a heat sealed cellophane bag, for one-time use.

Also available in the line is the Z-6000 Urethral-Duodenal Irrigation-Evacuation Multi-Purpose Syringe. It has double scale, 2 ounce or 50 cc, and is accurately calibrated in both ounces and cc's. It is non-breakable and can be used for all types of irrigation as well as other applications. It can be sterilized for re-use in any cold or wet sterilization agent or cold germicide. **Zoller Chemical Corporation, 3906 Wilshire Blvd., Los Angeles 5, Calif.**

For more details circle #225 on mailing card.

Electrophoresis Results in Minimum Time

Routinely reproducible results are supplied in a minimum of time with the Spinco Electrophoresis Apparatus. The simple, three-part system can be oper-

ated by clinical and research personnel without special training and the computation job is done automatically, in minutes, by the Analytrol. Composed of a Durrum-Type Electrophoresis Cell, Duostat and Analytrol, the system employs carefully standardized buffers, dyes and fixatives in pre-weighed, stable powder form. Selected pre-cut paper electrophoresis strips are also available. Both the "spectrum" and summation are on permanent record sheets for filing. Distributed by **Scientific Products Division, American Hospital Supply Corporation, Evanston, Ill.**

For more details circle #226 on mailing card.

Thermodynamic Steam Trap Employs Kinetic Energy

The Sarco Thermodynamic Steam Trap is a new and different steam trap in which the kinetic energy of steam closes the valve. The only moving part is the valve head, a solid heat-treated stainless disc, which ensures practically no maintenance, according to the manufacturer. The design and metals used enable this new steam trap to withstand superheat, water-hammer, vibration and corrosive condensate. **Sarco Co., Inc., Empire State Bldg., New York 1.**

For more details circle #227 on mailing card.

(Continued on page 252)

Surgery Table Has Explosion-Proof Motor

The explosion-proof motor elevation feature of the new Ritter Type 2-S-21 Multi-Purpose Surgery Table has Underwriters Laboratories approval, according to the manufacturer. The table features great flexibility and ease of positioning for all surgical procedures. All sections of the top are equipped with black static conductive rubberized upholstery and the mobile base has four static conductive rubber casters.

The motor-driven, hydraulic elevating base operates easily at a touch of the toe on one of the conveniently located foot pedals and can be raised or lowered to the exact height desired. The table has a full 18 inch elevation range from an extreme low position of 29½ inches to a high of 47½. It is equipped to handle most general surgery as well as many highly specialized operative procedures. It is easily adjusted for all required positions and the modern design of the locking arrangement allows a nurse of even slight build to secure any of the side rail attachments easily. The mobile base permits position where desired and a foot controlled floor lock immobilizes the base and offers complete stability when in use. **Ritter Company, Inc., Rochester 3, N. Y.**

For more details circle #228 on mailing card.

Daylighting Dome Serves Dual Purpose

Daylighting plus access to the roof are offered with the new Wascolite Hatchway. This functional building product admits overhead daylighting for corridors, closets, stair wells and other areas, and can be opened for ventilating, fire-venting and roof access. The Hatchway can be easily installed by one man.

The factory-assembled unit consists of a white translucent or clear colorless Wascolite acrylic dome, an aluminum dome frame, and aluminum curb with compensating spring for mounting directly on the roof opening. The ruggedly constructed units are designed to withstand years of outdoor weathering. The plastic domes provide good light dif-

fusion and light transmission without glare, are lightweight and shatter-resistant. **Wasco Flashing Co., 87 Fawcett St., Cambridge 38, Mass.**

For more details circle #229 on mailing card.

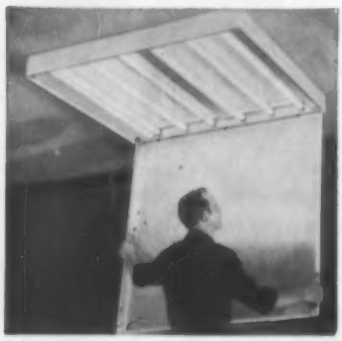
WHAT'S NEW

Modern, Attractive Furniture for Nurse and Staff Quarters

The Theme Unit Furniture designed for Simmons Company by Raymond Spilman, S.I.D., is available in a full line of pieces for dormitory use in nurses' homes and other staff residences. Simmons Beautyrest Sleep-lounges harmonize with the new design and provide comfortable rest while giving the room an attractive appearance for use as a sitting or a bed room. Basic pieces and tops can be combined to fill every need. Pieces in the line include single desk or Duet Desk providing work and storage area for two students in one compact unit, straight and arm chairs, coffee table, chest with sliding panels for easy access to clothing and other materials, and hanging cabinets with mirror paneled storage units.

Theme furniture has clean, modern lines with no corners or crevices to collect dirt, thus making it easy to maintain. It is finished in attractive colors which blend with all decorating schemes and give a cheerful, homelike atmosphere to the rooms. It is sturdily constructed of steel in modern designs and has brass and stainless steel glides on the tubular steel legs with brass hardware and trim. Where desired for extra durability, Textolite tops in special Theme designs are available for chest, desk and table tops. Room groupings of Theme furniture make attractive, comfortable quarters for nurses' and other staff members. **Simmons Company, Merchandise Mart, Chicago 54.**

For more details circle #230 on mailing card.



Lighting Fixture for On-Surface Mounting

The Omega-Plex fixture for on-surface mounting on existing ceilings is one in the series of Wakefield Geometrics. No structural changes are required and the unit may be used individually or combined in an unlimited variety of lighting designs. Ballasts and lampholders are in an individual metal housing that provides hook-on suspension points for the Wakefield Rigid-Arch Diffuser. The latter is molded with a sweeping arch for improved rigidity. The non-specular, matt finish minimizes possible reflected glare from outside the building. Omega-Plex is also available with louvers. **The F. W. Wakefield Brass Co., Vermilion, Ohio.**

For more details circle #231 on mailing card.

Blood Pressure Instrument for All-Purpose Use

The new Burton Manotest Blood Pressure Instrument is so designed that it can be used on the desk, with a special wall bracket or portable floorstand, or it can be carried in the pocket, bag or car. The time-tested mercurial blood pressure instrument provides full scale 300 mm measurement with mercury

accuracy sealed-in at the factory. Findings are claimed to be always comparable and accurate.

The large, angled scale is designed for natural easy reading from any angle or position. The instrument is corrected for position as well as for vibration or shock and is leakproof, to prevent the loss of mercury. It has a self-adjusting "quik-hook" cuff, extra long tube and convenient zipper carrying case. **Burton Manufacturing Co., 11201 W. Pico Blvd., Los Angeles 64, Calif.**

For more details circle #232 on mailing card.

Vacuum Cleaner Has High Dirt Capacity

Spic-Span Model 925M vacuum cleaner is especially suitable for schools, hospitals and other institutions where rapid clean-up is necessary. A special feature of this light-weight model is the pleated filter which allows for cooler motor operation and high cleaning efficiency in addition to high dirt capacity. **Premier Co., 755 Woodlawn Ave., St. Paul, Minn.**

For more details circle #233 on mailing card.

(Continued on page 254)

Self-Closing Lids for Ash and Garbage Cans

A new type of self-closing, push-top lid is now available for the Witt line of heavy duty ash and garbage cans. Made of 24 gauge Witt Perma-Zinc sheet steel, the push-top lid is available in 16, 18¾ and 20⅝ inch outside diameter sizes for 20, 27 and 33 gallon sized cans. An inside tension spring keeps the 8⅜ inch opening in the lid firmly closed when not in use. The lids produce more sanitary type refuse receptacles as they fit snugly yet are easily removed for emptying. **The Witt Cornice Co., 2119 Winchell Ave., Cincinnati 14, Ohio.**

For more details circle #234 on mailing card.

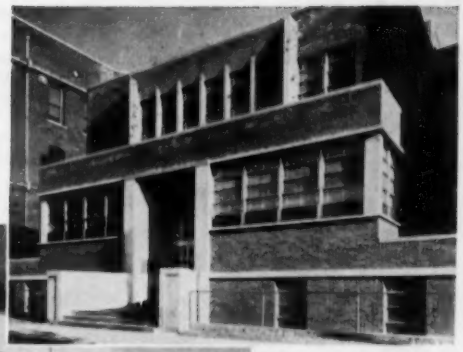
Efficient Mimeograph at Low Cost

Deluxe operating features are provided in the new Model 437 low-cost electric mimeograph. The table-top model has an enclosed cylinder, permitting the use of new mimeograph inks which dry on contact with the paper. It offers hairline registration, a full ream feed, a new dual roll feed that may be set to eliminate paper lint on copy areas or to avoid smearing pre-printed copy, and variable speeds from 90 to 180 copies per minute. Two ink pads can be used at one time on the machine for multi-color duplicating.

Operating controls on the Model 437 are clearly identified. Complete operating instructions are given on permanently attached metal decals, eliminating the need for instruction books which were often misplaced. The new machine

gives quality service and results at low cost. **A. B. Dick Company, 5700 W. Touhy, Chicago 31.**

For more details circle #235 on mailing card.



New addition, Frankford Hospital, Philadelphia, Pa. Architects: Gilboy, Bellante and Clauss, Philadelphia. Contractor: William F. Lotz, Philadelphia. Windows: Lupton Master Aluminum Projected Windows.

Forget about maintenance—build with Lupton Master Aluminum Windows

Barring accidents, first cost is last when the building is equipped with Lupton Master Aluminum Windows. There is no painting, even at installation, and there never will be any. Here is an immediate saving, plus additional savings as time goes on. In fact, these efficient windows will probably pay for themselves after a few years, through the savings they've made.

With Lupton Aluminum Windows, ventilators always fit snug, uninterrupted by thickening layers of clogging paint. Ventilation stays finger-tip controlled. Sash open and close quickly, evenly and smoothly, never bind or stick.

Engineer designed and backed by over 40 years of experience, Lupton Metal Windows offer beauty, service and efficiency. Whether you're planning a large building or a small one, a new one or an addition, you'll find the "right" window in the complete Lupton line. Your architect or building contractor can tell you more — or write direct for full information.

MICHAEL FLYNN MANUFACTURING CO.
700 East Godfrey Avenue, Philadelphia 24, Pa.

LUPTON METAL WINDOWS

Member of the Steel Window Institute and Aluminum Window Manufacturers' Association

WHAT'S NEW

Elastic Bandage With Lock-Knitting

A new lock-knitting process is used

in the manufacture of the Gross Elastic Bandage With Rubber. Thousands of air spaces are produced by the new process, allowing the skin to breathe and giving increased patient comfort. The construction permits the natural elimination of perspiration and reduces the danger of dermatitis. Maximum compression without danger of constriction is provided by the even pressure afforded with the new bandage. The Gross Elastic Bandage is available in widths ranging from 2 to 10 inches in the Hospital Pack or individually wrapped in cellophane.

The new bandage allows freedom of action in bandaged joints. It is fully washable and non-raveling and returns to its original size after tension. The special ribbing prevents slipping of the bandage. **Fairhope Fabrics Inc., Stevens St., Fall River, Mass.**

For more details circle #236 on mailing card.

Hearing Tests Facilitated With Portable Audiometer

Reliable performance, stable calibration and light weight are some of the features of the new Beltone Portable Audiometer designed for use in hearing tests. A sliding panel protects the face of the instrument when not in use and it can be easily carried from room to room or to various departments or buildings. It has a minimum number of component parts, resulting in infrequent adjustments and maintenance.

An automatic equalizer enables the

operator to read the hearing loss directly on the dial in group testing. Up to 40 persons can be tested at one time. The instrument has one bone conduction and two air conduction receivers for individual testing. **Beltone Hearing Aid Co., 2900 W. 36th St., Chicago 32.**

For more details circle #237 on mailing card.

Kompakt File Cabinet Gives Added Space in Same Area

A new file cabinet which provides five drawers of filing space in the same space usually occupied by a four drawer file is offered in the Kompakt. Modern styling is combined with increased capacity in the new units. The drawers float open easily and the Kompakt is constructed for long life. Recessed drawer pulls, offset label holders, rounded corners and Gray-rite finish are features of this efficiently designed unit. The file is also available in three, four, and six drawer sizes. **Remington Rand Inc., 315 Fourth Ave., New York 10.**

For more details circle #238 on mailing card.

AP Acrylic Skylight Provides Maximum Light

A thermoplastic acrylic resin dome of simple design, the AP Acrylic Skylight, sets into the roofing material. Light entering at the roof level gives the widest possible spread of daylight for maximum lighting efficiency. It is designed for use

on any flat roof and is easily installed by the roofer.

The AP Skylight is available in sizes to fit standard roof joist spacings and roof openings. Installation is such that nothing is exposed to wind and weather except the strong, one-piece arching dome. Flanges are imbedded and permanently protected in the roofing material, thus tightly sealing the opening. The AP Skylight is manufactured by Architectural Plastics, Inc., 20 Fitch St., East Norwalk, Conn., and distributed by **Austral Products Corp., 225 Broadway, New York 7.**

For more details circle #239 on mailing card.

Loose-Leaf Binder for Duplicated Material

Standard-spaced punching permits interchange of material in the new GBC binder. It is designed to bind anything duplicated, printed, typed or drawn, and to permit insertion or removal of material from any place in the book without taking the book apart. The metal loose-leaf binder is available in two basic wrap-around cover styles in a variety of colors. **General Binding Corp., 812 W. Belmont Ave., Chicago 14.**

For more details circle #240 on mailing card.

(Continued on page 256)

Constant Pulse Indication Provided by Vim Palpatron

Developed through the cooperative efforts of an electrical engineer and a prominent anesthesiologist, the Vim Palpatron is designed to fill the need for a method of providing a constant indication of pulse. The technical instrument is particularly effective for use in critical surgical procedures and comes complete with operating instructions. **MacGregor Instrument Co., Needham 92, Mass.**

For more details circle #241 on mailing card.

Redesigned Collar for Fin-Tube Heaters

A new deep-drawn fin collar has been developed by Kritzer as part of a retooling program. The new collar provides more intimate surface-to-surface contact between the fins and heat carrying tubes in the company's baseboard and fin-tube products. **Kritzer Radiant Coils, 2901 Lawrence Ave., Chicago 25.**

For more details circle #242 on mailing card.

High Speed Copying With Desktop Machine

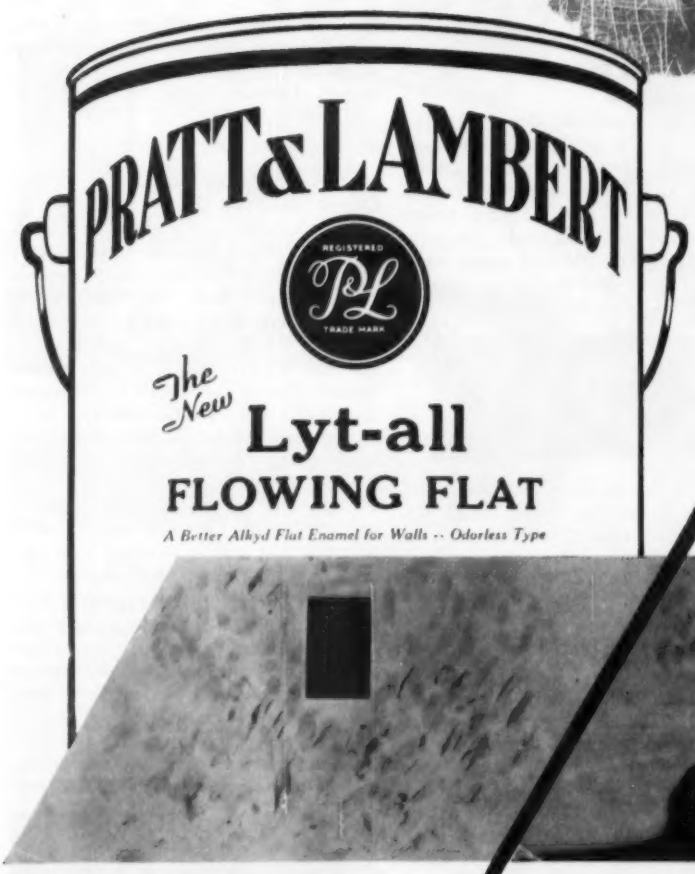
The Copyflex Series 100 model is a high speed desktop direct copying machine which makes up to 300 exact copies per hour. The cost for black-on-white copies is low and material up to 11 inches in width of any length can be reproduced on the machine. It occupies minimum space on the desk top.

The completely self-contained unit operates on the diazo direct copying process and requires no exhaust ducts, darkroom

facilities or plumbing. **Charles Bruning Company, Inc., 4700 Montrose Ave., Chicago 41.**

For more details circle #243 on mailing card.

WILL THE WALL PAINT YOU USE PASS THE HAND PRINT TEST?



This one will! Hand prints, ink, crayon, pencil, most antiseptics and other stubborn stains wash right off walls painted with Pratt & Lambert *New* Lyt-all Flowing Flat. This means REAL MAINTENANCE ECONOMY! You'll like its freedom from objectionable odor, too, for it means normal activities can continue even while painting is in progress. Choose Pratt & Lambert *New* Lyt-all Flowing Flat in any of 109 exclusive job-tested colors next time you have walls to paint.

This is the hand print test! See how easily hand prints wash off walls painted with Pratt & Lambert *New* Lyt-all Flowing Flat.

Other stubborn stains wash off just as easily. Repeated washings will not harm the velvet finish and lovely colors of this self-priming alkyd flat enamel.

REGISTERED
TRADE MARK

PRATT & LAMBERT-INC.

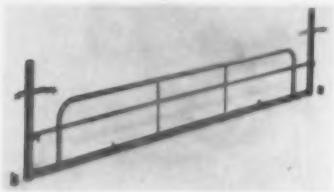
A Dependable Name in Paint since 1849

NEW YORK • BUFFALO • CHICAGO • FORT ERIE, ONTARIO

WHAT'S NEW

Safety Sides Slide Easily to Position

The Hard 1505-PG Slida-Side Safety Sides are full length bed guards which combine strength with light weight and



ease of handling. They slide straight up and down and require a minimum of space. Footstool or overbed table can be used under the bed even when the sides are down, due to their unique design. A finger-tip release permits easy operation of the sides which slide quietly up or down on nylon rollers with a minimum of effort. The sides attach quickly to bed ends by means of two clamps and two hooks which fit snugly into sockets permanently attached to the ends. The sides can be left on the bed since they lower sufficiently to permit bed making without bumping the nurse's legs. **Hard Manufacturing Co., 117 Tonawanda St., Buffalo 7, N.Y.**

For more details circle #244 on mailing card.

Plastic Panels for Light Diffusion

Two new plastic panels have been introduced by Celotex for ceiling installation for high light levels. Uniform light transmission without glare is achieved with the panels which have attractive embossed designs in four basic patterns. They are also available in special designs for custom installations.

Lumicel is a plastic panel for translucent ceiling installations. Acousti-Lux is a pair of plastic panels welded together at their perimeters to provide sound absorption through diaphragmatic action of the air space. Both light diffusion and noise reduction are provided by Acousti-Lux ceilings.

Panels are 24 by 24 inches, made of white vinyl chloride acetate plastic and installed by means of a metal suspension system. They can be moved when necessary but are kept in place with mechanical devices. The panels have an anti-static coating to repel dust but they may be removed for washing when necessary. **The Celotex Corporation, 120 S. La Salle St., Chicago 3.**

For more details circle #245 on mailing card.

Economy and Lightness in Institutional Door

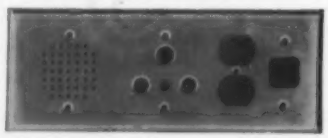
The economy and lightness of the hollow core door are combined with the heavy blocking necessary to accommodate institutional hardware in the new institutional door developed by General Plywood. Top and bottom rails for mounting door closers, kick plates and other hardware are ten inches wide. An extra center cross rail and two 40 inch lock blocks are provided for installing panic bars, large locksets and heavy door pulls. The hazard of hanging errors is eliminated as the doors are reversible top to bottom and left to right.

A core of cylindrical fiber columns gives the door lightness while the use of three-ply balanced face panels, hot plate pressed with core and frame into one integral unit, maintains heavy duty strength for use in hospitals, schools and other institutions. **General Plywood Corporation, 3131 Market St., Louisville, 12, Ky.**

For more details circle #246 on mailing card.

Electrical Face-Plates in Special Sizes

Special face-plates for electrical outlet boxes can now be made to fit any need. Face-plates of from one to six-gang, with outlets in any desired sequence, can be made at standard price. Special orders are required for sizes over six-gang. Plates are made of .036 inch gauge stainless steel, satin finished and lacquer coated. Black phenolic plates can also be



supplied to specifications, engraved with whited or color-filled letters. **The Colonial Electric Co., 11462 Euclid Ave., Cleveland 6, Ohio.**

For more details circle #247 on mailing card.

Floor Finishing System Is Fast Drying

Both a sealer and an alkyd varnish of special formulation are used in the new Sherwin-Williams one-day floor finishing system. Applicable to new building construction and to floor maintenance in public or institutional buildings, the new system permits refinishing with a minimum of out-of-service time. The sealer dries within an hour and a half or two hours after application. It may be applied by brush, mop, squeegee or spray. The clear alkyd varnish is dust-free in one hour and completely dry in six to eight hours under normal atmospheric conditions. The varnish may be brushed or sprayed to produce a full gloss finish that is resistant to water, tea, coffee, fruit juices, alcohol and other liquids. It is sufficiently durable for use on exterior surfaces as well as on interior woodwork, furniture and floors. **The Sherwin-Williams Co., 101 Prospect Ave. N. W., Cleveland 1, Ohio.**

For more details circle #248 on mailing card.

(Continued on page 258)

Pneumatic Tube System Is Prefabricated

A two-station pneumatic tube system is now available in kit form for installation by the regular maintenance personnel in any type of building. Available at the cost of the equipment alone, the complete packaged kit assembles into a two-way system connecting points up to 130 feet apart. It is pre-engineered so that it can be laid out and installed by following the simple instructions.

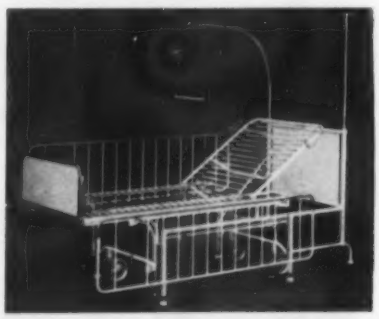
The packaged Airtube system can be installed in a variety of configurations to connect points on either the same or different floor levels. Messages and other paperwork are moved through the tubes in air-propelled carriers at a speed of 20 feet per second, providing fast, economical and convenient paperwork transit within the hospital at any time of the day or night, without extra personnel. **Lamson Corp., Syracuse, N.Y.**

For more details circle #249 on mailing card.

Mobile Stretcher Bed Offers Multiple Uses

Manufactured in Sweden, the Mobile Ericsson Bed is a versatile unit for medical, surgical, orthopedic and post-operative recovery care. The Type A bed normally rests firmly on legs but a single lever retracts the legs and transforms the bed into an easy-rolling stretcher when desired. One of the wheels automatically slips into a fixed position for easy steering by one person. A grab bar at the head of the bed can be used when it is rolled by one attendant.

The use of the stretcher-bed eliminates transfer of the patient from bed to stretcher and the easy-rolling unit permits the patient to remain on the bed from point of admission throughout his stay. The bed is wheeled to operating room, x-ray or other department and the intravenous stand is attached when required. The patient can be wheeled from his room to a private area for surgical dressings or special treatments and other care. Attachments are available for converting the bed for every need. The mo-

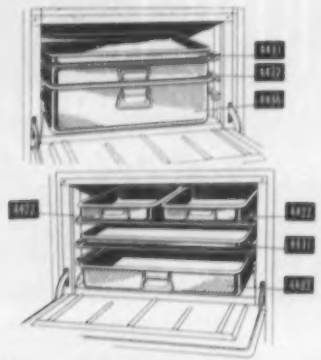


bile bed is also available for cardiac and polio drainage cases. It is now distributed in the United States by **Kibitz and Co., 545 Fifth Ave., New York 17.**

For more details circle #250 on mailing card.

WHAT'S NEW

Aluminum Pans for Modern Ranges



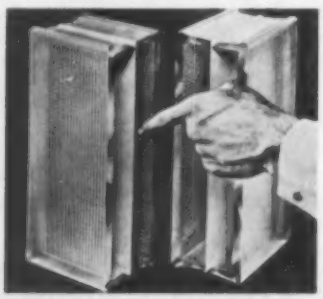
A set of seven new Wear-Ever aluminum roasting and baking pans has been developed with straight sides to utilize oven space to the best advantage. Several different baking combinations can be arranged in each oven with the new line which is designed for use in modern ranges now used in institutional kitchens. Time and fuel are saved by the arrangements possible with the new pans.

Included in the line are two types of pans, one for full-oven size and one for twin-oven size, with the shallow pans designed to serve as covers or as separate roasters. When the shallow pans are used as covers the unit becomes a steam-seal roaster. At least fourteen different combinations are possible with the set of new pans which are made of hard aluminum alloy with seamless construction throughout for easy cleaning and sanitation. A spring-type handle makes for easy handling and no waste space. **The Aluminum Cooking Utensil Co., Inc., New Kensington, Pa.**

For more details circle #251 on mailing card.

Controlled Light With Suntrol Glass Blocks

A soothing glow of daylight is transmitted through the new, double cavity glass blocks known as Suntrol. Pale green fibrous glass diffusing screens sealed



into the centers of the hollow glass blocks and the two partial vacuums keep out much of the sun's heat while transmitting non-glare light. The psychological effect of the light coming through the green filter is a cooler and more relaxed environment, regardless of the temperature.

The blocks, for exterior walls and roofs, are a new addition to the line of functional glass blocks which direct light rays where needed. They provide controlled illumination through direction and diffusion. The cut section in the illustration shows the light controlling prisms on the inner surfaces and the fibrous glass screen for reducing heat transmission and excessive brightness. Blocks are set to direct the light where needed, according to the elevation. **Pittsburgh Corning Corp., 1 Gateway Center, Pittsburgh 22, Pa.**

For more details circle #252 on mailing card.

Louver-Diffuser Is Versatile Unit

The GrateLite Louver-Diffuser, made up of thousands of open ⅜ inch cubes, can be used as a bottom in all new Guth fluorescent fixtures. These cubicles maintain low brightness with high foot candles, provide excellent shielding and diffusion, reduce room noise and diffuse air conditioning. GrateLite's closely spaced vanes make it able to stand severe usage. **The Edwin F. Guth Co., 2615 Washington Blvd., St. Louis 3, Mo.**

For more details circle #253 on mailing card.

Nylon Hand Scrub Designed for Easy Stacking

Nylon back as well as bristles are used in the new Grafco All-Nylon Hand Scrub offered by Graham-Field. The special design permits easy stacking of the brush for storage, resulting in space saving and secure stacking without toppling over. The brushes are designed to withstand countless autoclavings with tufts anchored with non-corrosive nickel-silver wire. The bristles are stiff enough for thorough scrubbing action without scratching the skin. **Graham-Field, 32-56 62nd St., Woodside 77, N. Y.**

For more details circle #254 on mailing card.

Coffee Hottle Has Improved Collar

The individual coffee carafe that fits in the cup—the Glasbake Coffee Hottle—is now manufactured with a new collar. It is made of a special plastic which will withstand even the live steam and boiling water used in commercial dishwashing machines without chipping, peeling or unraveling.

The Coffee Hottle holds two cups and saves space on the serving tray or table while keeping the cup and the coffee or other beverage warm. The Hottle comes

in either clear or milk-white heat-resisting glass and the new collars are available in five colors for cheerful and attractive service. Crest or insignia of the institution can be fire-glazed into the glass on one or both sides. **The McKee Glass Division, Thatcher Glass Manufacturing Co., Inc., Elmira, N.Y.**

For more details circle #255 on mailing card.

Removable Vacuum Unit on Heavy Duty Model

The new Series 80 heavy duty Tornado Vacuum Cleaner is a versatile unit. The motor or power unit can be removed by a quarter turn from the top of the tank cover and converted into a portable electric blower, a pack carried vacuum cleaner, an insecticide sprayer or an air sweeper for removal of paper and debris. A large sized tank cover plate is available to fit any empty 55 gallon drum so that, with a large sized filter bag, the capacity of the cleaner can be increased.

The air speeds for cleaning and blowing have been greatly increased through use of a new type air impeller. The new type motor does not overheat or burn out, even when operated under constant maximum load. The stainless steel tank of the machine itself has a 15 gallon capacity for wet or dry pickup. Maxi-

mum filter efficiency with long life are features of the new dust filter bags. **Breuer Electric Mfg. Co., 5100 N. Ravenswood Ave., Chicago 40.**

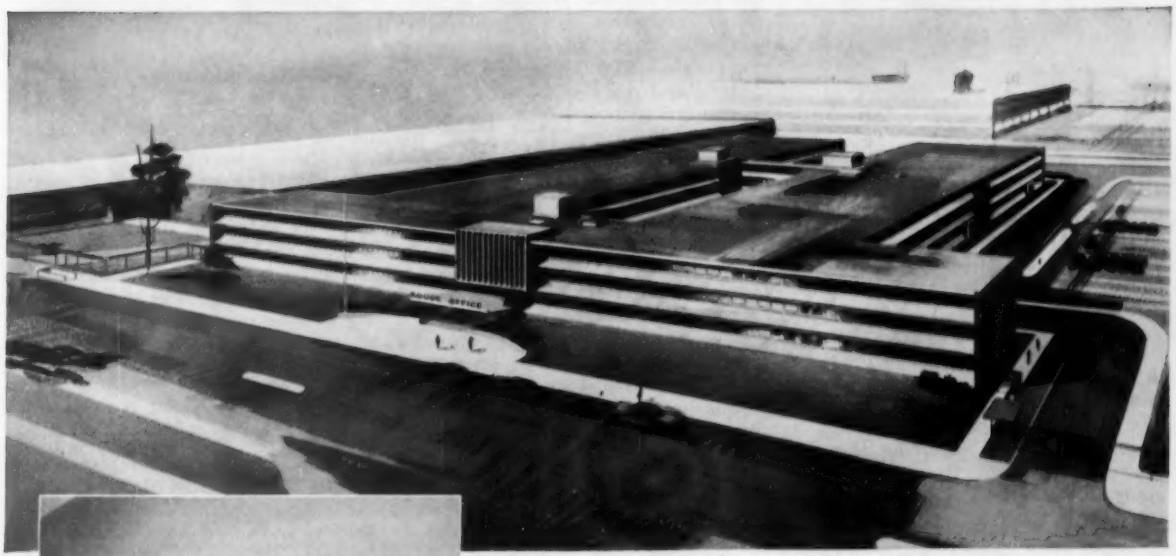
For more details circle #256 on mailing card.

(Continued on page 260)

Enhancing the Modern Beauty of this new

FORD Motor Co. Office...

the Modern Door Closer... NORTON *"INADOR"*



See how unobtrusively the "Inador" installs, as shown here on an interior door of Ford's new Rouge Office Building, Dearborn, Mich. Eberle M. Smith Associates, Inc., Dearborn, Mich. are the architects and Long Construction Company, Kansas City, Mo., the contractors.

Only The "INADOR" has all these top-quality NORTON features.

- ✔ **Rack and Pinion Construction** gives uniform, positive checking at every point!
- ✔ **New Aluminum Shell** for lighter weight, robust wear. Proved by use on our surface closers for over 7 years.
- ✔ **Special Spring**—of highest quality steel!
- ✔ **Non-Gumming, Non-Freezing Hydraulic Fluid** *permanently* lubricates every inside moving part!
- ✔ **Double Adjusting Levers,** easily moved by fingers, control speed of closing action and latching action!
- ✔ **Regular Arm Series and Holder Arm Series**—the latter especially suited for hospital use!
- ✔ **Famous Guarantee!** For 2 full years, providing recommended sizes are used!

Only a Liquid Closer gives so much ***Rugged Dependability!***

Only Concealed Design gives so much ***Modern Beauty...*** **it's the**

NORTON *"INADOR"*

Headquarters for five Ford manufacturing divisions will be the new Rouge Office Building at Dearborn, Michigan. The 3-story, 369,000 square foot structure, utilizing the unusual "lift slab" method of construction, features handsome, modern styling. And it's designed, too, to "stand-up" under unusually heavy use, for the years to come!

As a result, it represents an ideal application for Norton "Inador" Closers, which were selected for interior door control. The "Inador's" construction preserves the building's trim, functional beauty. Yet, since the "unseen" mechanism is of the true Liquid Type, it provides the full measure of reliability —for smooth, low-maintenance operation in heavy-traffic use!

These are the reasons why *you* should choose Norton "Inador" for that new building of yours that needs the best in rugged, modern closers!

Write today for FREE Catalog on full Norton line of Concealed and Surface Door Closers.

NORTON®

Dept. MH35 Berrien Springs, Michigan

"Over 70 Years of Leadership in the Door Closer Industry."

WHAT'S NEW

Floor Machines in Three Sizes

The Model 800 Series Finnell Motor Weighted Floor Machine is offered in 15, 18 and 21 inch diameter brush spread. The simplified brush construction equalizes the flow of the scrubbing solution and reduces brush replacement. Excellent balance from careful weight distribution on the brush makes for ease of operation.

The General Electric motor varies from ½ to one h.p., depending upon the size. Power is transmitted through a planetary drive system, making for extra high power transfer to the working brush. The machine has accessories for all floor maintenance needs, including that for shampooing carpets. It can be used to apply wax if desired. The solution tank on the handle is streamlined for minimum space and maximum efficiency. **Finnell System, Inc., 1400 East St. Elkhart, Ind.**

For more details circle #257 on mailing card.

Utensil Washer Uses No Detergent

The FMC Utensil Washer is now available in a single compartment model for the small kitchen. Money is saved in the cleaning of pots and pans of all sizes and shapes since no detergents or soaps

are required with the washers. Labor costs are reduced also since pots and pans come out completely clean and greaseless. In a matter of minutes even the dirtiest pots and pans are washed, scoured, rinsed and sterilized. The washer is compact in design and takes minimum space in the kitchen or clean-up department. **Food Machinery & Chemical Corp., Hoopeston, Ill.**

For more details circle #258 on mailing card.

Rib Belt of Tailored Elastic

Maximum comfort with firm support and perfect fit are offered in the new Aloe Elastic Rib Belt. It is made of flesh-colored interwoven rubber and cotton with white webbing straps and adjustable buckles. The belt can be removed instantly and quickly put on. There is no skin irritation and it is available in models for men and for women. No metal touches the skin and special tailoring assures perfect fit. **A. S. Aloe Company, 1831 Olive St., St. Louis 3, Mo.**

For more details circle #259 on mailing card.

Liquid Duplicator Has Position Control

Copy can be raised or lowered from a small fraction of a line to seven lines with the new Margi-Set Copy-rite. Even hair-line registration is simplified with the new machine which incorporates a

visible indicator to show the setting at all times. Copy can be changed even while the machine is operating but is locked in place automatically. The new duplicator has the Copy-rite features of lift-out rollers for easy replacement when necessary, all aluminum contour design fluid container, single or multi-color reproductions and durable construction. **Wolber Duplicator & Supply Co., 1201 Cortland St., Chicago 14.**

For more details circle #260 on mailing card.

Four Drawer File Insulated for Record Protection

A new four drawer, letter size Diebold Insulated File has been developed to provide safe-type one hour fire protection for vital records. The manufacturer states that the file carries the Underwriters' Laboratories Class "C" Insulated Record Container Label which includes the impact or drop test. The file has completely extendable and easily removable drawers for ready access, rubber cushioning stops and roller bearings for operating ease and years of trouble-free service. Each compartment is insulated for added protection and there is a full steel lining inside each drawer compartment. **Diebold, Incorporated, Canton 2, Ohio.**

For more details circle #261 on mailing card.

(Continued on page 262)

Vertical Conveyor for Books and Records

Books, records and documents are transferred with speed and convenience with the Uni-Strand Vertical Conveyor. The Conveyor is a vertically moving belt with finger type carriers, each designated for unloading at a specified area. It is designed for specific application and can be arranged for loading and unloading at any given number of floors. Loading is done manually but unloading is an automatic procedure. **Samuel Olson Mfg. Co., Inc., 2433 Bloomingdale Ave., Chicago 47.**

For more details circle #262 on mailing card.

Super Cuber Makes 500 Pounds of Ice Daily

Built to specifications requested by hospital and other institutional users of ice cubes, the new Scotsman Automatic Super Cuber makes 500 pounds or 10,000 Super-Cubes of ice per day. It is designed to occupy minimum floor space and produces a round, completely solid, crystal clear cube.

The SC-500 Super-Cuber features "Cycle-Matic" controlling, a system that automatically compensates for unpredictable changes and variances in room temperature, water temperature and water supply pressure. The solid ice cubes are uniform and slow melting, the machine requires low water and power consumption, it is easily installed

and has automatic operation. **American Gas Machine Co., Division of Queen Stove Works, Inc., 505 Front St., Albert Lea, Minn.**

For more details circle #263 on mailing card.

WHAT'S NEW

Institutional Formula for Bleaching Cleanser

The benefits of a modern grease-cutting cleaner specially designed to remove stains and brighten porcelains are to be found in the new formula cleanser, Bab-O with Bleach. Developed especially for institutional use, Bab-O with Bleach is available only through institutional wholesalers, jobbers and maintenance suppliers. **B. T. Babbitt, Inc., 386 Fourth Ave., New York 16.**

For more details circle #264 on mailing card.

Cold Water Source for Air Conditioning Systems

Factory-assembled packaged water chillers are now available as a cold water source for all air conditioning systems. The new line has circuits completely piped, wired and tested and the packages range in size from 2 to 75 h.p. for use in buildings of all sizes. The small sizes have a hermetically-sealed motor and compressor assembly mounted within a rigid steel frame. Units are complete with factory-charged refrigerant circuits and require only simple piping and electrical connections for use.

The addition of packaged water chillers to the American-Standard line provides complete room and central station equipment for all multi-room air conditioning systems. **American Radiator & Standard Sanitary Corp., P.O. Box 1226, Pittsburgh 30, Pa.**

For more details circle #265 on mailing card.

Wax-Base Finish Protects Terrazzo Flooring

Protection against water, stains and dust is offered in Terra-New Terrazzo Seal. This new wax-base finish is designed to protect terrazzo, marble and ceramic tile floors. Heavy traffic areas can be touched up as needed and blended in with the finish on the rest of the floor. The finish is colorless and provides a high gloss without slipperiness. One gallon covers approximately 1,500 square feet and the product is available in 1, 5, 30 and 55 gallon drums. **S. C. Johnson & Son, Inc., Racine, Wis.**

For more details circle #266 on mailing card.

Efficiency Unit for Floor Kitchens

A new unit is announced which should prove efficient for installation in floor kitchens, nurses' homes, personnel quarters and other areas requiring kitchen facilities. The efficiency kitchen unit contains a large sink, a range and a full five cubic foot refrigerator in a space covering 2 by 2½ feet. The range is available with either electric or gas heat in the two burners. **Acme National Refrigeration Co., Inc., 29-24 40th Ave., Long Island City, N.Y.**

For more details circle #267 on mailing card.

Pharmaceuticals

Normal Serum Albumin (Human) Salt-Poor

Normal Serum Albumin (Human) Salt-Poor is a 25 per cent solution of the albumin fraction from pooled, normal human plasma, containing no preservative. It has been sterilized by filtration and by heating. Indicated in treatment of shock due to trauma, hemorrhage, operation or infection, in treatment of severe injuries, burns and hypoproteinemia, and for prevention and therapy of cerebral edema, the product is administered only intravenously. It is supplied in 50 cc bottles, each containing 12.5 gm. normal serum albumin in 50 cc buffered diluent. A complete administration set is supplied with each bottle. **Hyland Laboratories, 4501 Colorado Blvd., Los Angeles 39, Calif.**

For more details circle #268 on mailing card.

Tyzine

Tyzine brand of tetrahydrozoline hydrochloride is an odorless and tasteless spray for nasal decongestion. It neither stings nor burns, does not induce rhinorrhea and provides almost immediate relief for a matter of hours. Tyzine is provided in convenient plastic bottles containing 15 cc of an 0.1 per cent aqueous solution and as nose drops in one ounce bottles. **Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., 630 Flushing Ave., Brooklyn 6, N. Y.**

For more details circle #269 on mailing card.

Lytren

Lytren is a complete, well balanced electrolyte mixture for oral use. It is designed to maintain both fluid and electrolyte balance by mouth in cases of fluid loss in diarrhea and vomiting. Supplied in convenient powdered form, Lytren is easily dissolved in water to form a pleasant-tasting solution. It supplies well balanced amounts of all the electrolytes of both extracellular and intracellular fluids. **Mead Johnson & Company, Evansville 21, Ind.**

For more details circle #270 on mailing card.

Mictine

Mictine is an oral diuretic which is primarily indicated in the treatment of patients with mild congestive heart failure to control edema initially, and as continuing therapy to assure an edema-free state. Since it is not a mercurial, a xanthine or a sulfonamide, it may also be used for initial and continuing diuresis in patients with more severe congestive failure. Mictine is supplied in bottles of 100 uncoated tablets of 200 mg. each. **G. D. Searle & Co., P. O. Box 5110, Chicago 80.**

For more details circle #271 on mailing card.

(Continued on page 264)

Product Literature

• Working floor plans of 23 active pharmacies serving hospitals of 80 to 1500 beds are shown in the new **"Portfolio of Designs of Hospital Pharmacies"** published by Parke, Davis & Company, Detroit 32, Mich. Two pages are devoted to designs of pharmacies in hospitals with less than 150 beds, four pages to those in hospitals with 150 to 300 beds and 12 pages to those in hospitals with more than 300 beds. Layouts and departmental information have been provided through the courtesy of the hospital pharmacists in charge, according to the company, and plans presenting a wide variety of layouts and arrangements were selected. The hospitals used are named and the plans should have suggestive information for any hospital administrator, architect or pharmacist planning a new or remodeled pharmacy.

For more details circle #272 on mailing card.

• Alundum aggregate for terrazzo and cement floors is discussed in **Catalog 1935** released by the Norton Co., Worcester, Mass. The non-slip protection and wear resistance of Alundum floor products is stressed and the various products are illustrated and described in detail. Typical installations are also pictured in the eight page catalog.

For more details circle #273 on mailing card.

• A condensed but complete product guide for its entire line of high and low pressure steel boilers has been released by Kewanee-Ross Corp., Kewanee, Ill., in the revised edition of their **General Catalog, Number 80,** for 1955. The colorful 32 page catalog also contains full descriptions and illustrations of Kewanee water heating products. An index and tables make for easy reference.

For more details circle #274 on mailing card.

• The full story on **Vampco All-Aluminum Windows** is told in a 40 page catalog recently released by Valley Metal Products Company, Plainwell, Mich. Specifications, detail drawings, glazing data and other factual information is given together with illustrations showing construction processes as well as hospitals and other buildings in which Vampco All-Aluminum Windows are installed.

For more details circle #275 on mailing card.

• A new report entitled **"Specifications for Cleaners for Use on Asphalt Tile Floors"** has been announced by The Asphalt Tile Institute, 101 Park Ave., New York 17. It was developed by the Institute's Technical Research Committee to cover the many new products in the maintenance field. It is designed to indicate not only all products that have injurious effect on asphalt tile, but also those that will be irritating to the human skin.

For more details circle #276 on mailing card.

WHAT'S NEW

• A complete index to all **Aerocor Insulations** is available in a new eight page booklet released by Owens-Corning Fiberglas Corp., Toledo 1, Ohio. Each type of insulation is illustrated and described under the headings of "Product Description," "Performance," "Suggested Use," "Application Methods" and "Sizes."

For more details circle #277 on mailing card.

• Applications of **Vicrtex fabrics on "Walls of Fame"** are shown in a new booklet released by L. E. Carpenter & Co., Inc., Empire State Bldg., New York 1. The 12 page booklet describes the properties of Vicrtex and shows the full range of 36 House & Garden colors and many three-dimensional Vicrtex patterns in addition to giving interesting decorating ideas. An actual swatch of the "Safari" pattern is included.

For more details circle #278 on mailing card.

• A folder which will be helpful to architects, engineers and consumers has been announced by the Corrulux Div. of Libbey-Owens-Ford Glass Co., P. O. Box 20026, Houston 25, Texas. Entitled **"What to Look for in a Good Translucent Building Panel,"** the new folder contains an outline of product standards for translucent fiber glass-reenforced panels.

For more details circle #279 on mailing card.

• Facts about **air conditioning an entire building** with individual packaged units are given in a brochure released by Philco Corp., Tioga & C Sts., Philadelphia 34, Pa. In addition to stating the advantages of such a system, a factual **report** is included which tells how a building was air conditioned with the individual packaged units and the results of the installation.

For more details circle #280 on mailing card.

• **Catalog No. 675,** released by The National Radiator Co., Johnstown, Pa., describes National commercial steel boilers with Wing induced draft fans. The eight page catalog is illustrated and gives specific examples where Wing induced draft fans are particularly advantageous.

For more details circle #281 on mailing card.

• The 1955 catalog on **Flexicore Precast Prestressed Concrete Slabs for Floors and Roofs** has been released by The Flexicore Co., Inc., 1932 E. Monument Ave., Dayton 1, Ohio. The eight page catalog outlines properties and uses of the slabs, diagrams basic structural and mechanical details and describes erection procedure.

For more details circle #282 on mailing card.

• A new bulletin on **Gyra-Flo Power Exhausters** has been issued by the Chicago Blower Corporation, 9867 Pacific Ave., Franklin Park, Ill. Detailed information on the description, application and specifications of the exhausters is given. Performance tables are also included.

For more details circle #283 on mailing card.

• All Yale key blanks and locksmiths' supplies and tools are covered in the new **Locksmith Supply Catalog** section issued by Yale & Towne Manufacturing Co., Stamford, Conn. The 32 page book contains comprehensive indices to key blanks, a section on repair parts and a section on repair tools and key duplicating machines. It should prove of value to maintenance departments and engineers.

For more details circle #284 on mailing card.

• The full line of **Arketex Ceramic Glazed Structural Tile** is discussed and illustrated in a new catalog recently **released by The** Arketex Ceramic Corp., Brazil, Ind. Typical installations are shown and construction details are given in this 28 page catalog.

For more details circle #285 on mailing card.

• Typical installations of the various types of **Mills Metal Partitions** for toilet compartments, shower and dressing rooms, shower units and hospital cubicles are described and illustrated in two-tone color combinations in a new catalog released by The Mills Co., 997 Wayside Rd., Cleveland 10, Ohio. Illustrations of all standard hardware and fittings are included. A special feature of the catalog is a color chart of the 20 Mills standard colors to aid in color planning.

For more details circle #286 on mailing card.

• The new **Korelock prefinished hollow-core ceiling and wall paneling** are discussed in a folder released by Marsh Wall Products, Inc., Dover, Ohio. Photographs show typical Korelock interiors, both in new construction and remodeling. Also shown are the ten "Companion Colors" and the four wood patterns styled by Raymond Loewy Associates especially for Korelock.

For more details circle #287 on mailing card.

• **"Stainless Steel Equipment . . .,"** what it is and where it is used, is discussed in a bulletin published by Armco Steel Corp., 1054 Curtis St., Middletown, Ohio, for hospital administrators, architects and department heads. A reference chart shows which types and grades of stainless steel are used for all principal applications in hospitals and includes everything from general hospital equipment to surgical instruments. Photographs of actual installations supplement the descriptive text.

For more details circle #288 on mailing card.

Book Announcements

Alexander, "Reactions With Drug Therapy," 301 pp., $7.50. Hansen, "Study Guide and Review of Practical Nursing," 419 pp., $3.75. Read, "The Nursery School: A Human Relationships Laboratory," 2nd Ed., 297 pp., $4. **W. B. Saunders Co., Washington Square, Philadelphia 5, Pa.**

For more details circle #289 on mailing card.

Suppliers' News

Beaver-Advance Corporation is the new corporate name of the **Beaver Art Metal Corporation, Ellwood City, Pa.,** designers and manufacturers of tubular steel scaffolding and hoisting towers.

Federal Fibre Corp., 3704 Tenth St., Long Island City 1, N. Y., manufacturer of Fiberok baskets, cans and receptacles and Fedco boxes and box trucks, announces appointment of **Philip Shore & Associates,** 2881 E. Pico Blvd., Los Angeles 23, Calif., as its representative on the West Coast.

The Hausted Manufacturing Company, Medina, Ohio, manufacturer of wheel stretchers, announces the completion of a plant expansion program including the acquisition of a new building for the manufacturing operations. Increased production and efficiency and improved service to the field are the results of the expansion program.

Ohio Chemical & Surgical Equipment Co., 1400 E. Washington Ave., Madison 10, Wis., manufacturer of medical gases and therapy oxygen, oxygen pipeline equipment and anesthetic, therapeutic and resuscitative apparatus, announces its retirement from the manufacture and sale of sterilizers, lights, tables and cabinets as of February 15, 1955. The company states that all uncompleted contracts will be filled but that no new contracts for these items will be accepted. Arrangements are being made with the **American Sterilizer Company, Erie, Pa.,** to service this equipment in future, according to the announcement, and they will have the necessary designs and tooling to produce repair and replacement parts economically. The **Ohio Chemical & Surgical Equipment Co.** will continue to serve the needs of the field in connection with anesthesia apparatus and oxygen therapy equipment, oxygen, medical gases, sutures and Stille instruments.

Pittsburgh Plate Glass Company, 632 Fort Duquesne Blvd., Pittsburgh 22, Pa., manufacturer of paints, glass, chemicals, brushes, plastics and fiber glass, announces the opening of a new modern structure housing the basic and applied research laboratories of the paint and brush division at Springdale, Pa. The new laboratory is "dedicated to the creation and experimental production of new chemical compounds, paints, varnishes, enamels and lacquers, resins and plastics."

United States Plywood Corporation, 55 W. 44th St., New York 36, manufacturer of plywood paneling, doors, Kalistron wall covering and other structural materials, announces the construction of a new branch warehouse and office at **909 E. Madison St., Phoenix, Ariz.,** which will more than double the area presently occupied by the company.

PRODU

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210 Class A Movable Walls
Johns-Manville

211 Tylec Pressure-Sensitive Tape
Johnson & Johnson

212 Close-Up Attachment
Eastman Kodak Co.

213 Cubicle Curtain Track
H. L. Judd Div., The Stanley Works

214 Plastic Surfacing
Consoweld Corp.

215 Unarco "Dual-Vector"
Union Asbestos & Rubber Co.

216 Motor Driven Bed
Hill-Rom Inc.

217 Heat Recorder-Totalizer
Heat-Timer Corp.

218 Steel Frame Utility Carts
Lakeside Mfg. Inc.

219 Bolta Carafe
Bolta Products

220 Speedline Flatwork Ironer
American Machine & Metals Inc.

221 Glazed Structural Facing Tile
Metropolitan Brick Inc.

222 B&S Saddle Stapler
Bostitch

223 Crescent Gift Cart
Crescent Metal Products Inc.

224 Electro-Air Cleaner
Electro Air Cleaner Co.

225 Sterile Disposable Syringes
Zoller Chemical Corp.

226 Electrophoresis Apparatus
American Hospital Supply Corp.

227 Thermodynamic Steam Trap
Sarco Co. Inc.

228 Multi-Purpose Surgery Table
Ritter Co. Inc.

229 Wascolite Hatchway
Wasco Flashing Co.

230 Theme Unit Furniture for Nurses' Homes
Simmons Co.

231 Omega-Flex Lighting Fixture
The F. W. Wakefield Brass Co.

232 Blood Pressure Instrument
Burton Mfg. Co.

233 Vacuum Cleaner
Premier Co.

234 Trash Can Lid
Witt Cornice Co.

235 Electric Mimeograph
A. B. Dick Co.

236 Gross Elastic Bandage
Fairhope Fabrics Inc.

237 Portable Audiometer
Beltone Hearing Aid Co.

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March, 1955

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

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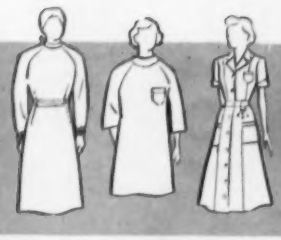

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